

The cover features a light gray background with three overlapping circles. The top-left circle is dark blue with a white border and contains a photograph of several hands of different skin tones stacked together. The top-right circle is a medium blue with a white border and contains white text. The bottom circle is a light blue with a dashed white border and contains dark blue text. The overall design is clean and modern, emphasizing community and health equity.

REACH

for
Health
Equity

RACIAL AND
ETHNIC
APPROACHES
TO COMMUNITY
HEALTH

A Look at How Six Minority-Serving
National Organizations Are Working to
Decrease Health Disparities





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APPEAL



Black
Women's
Health
Imperative



COUNCIL OF MICHIGAN, INC.



JOINT CENTER
FOR
POLITICAL AND ECONOMIC
STUDIES

NCLR
NATIONAL COUNCIL OF LA RAZA





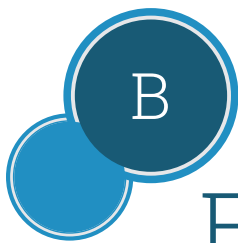


Foreword

The Racial and Ethnic Approaches to Community Health National Organizations that Serve Minority Communities (REACH MNO) funding announcement was launched by the Centers for Disease Control and Prevention in 2009, and six programs were funded. Through local affiliates and chapters, the REACH MNO awardees provide training and technical assistance in two areas: 1. Dissemination of evidence-based strategies and tools and 2. Capacity-building. The REACH MNO Success Stories were written by each funded organization to share their experiences and provide guidance to others committed to eliminating racial and ethnic disparities in health through prevention and management. The accomplishments highlighted in this booklet showcase the impact of national organizations working with local communities to close the health disparity gap among racial and ethnic minority groups.

The Program Officer for the REACH MNO initiative was Charlotte D. Kaboré, MS, MPH, MCHES, Lieutenant, U.S. Public Health Service Commissioned Corps, Public Health Advisor at the Centers for Disease Control and Prevention, Division of Community Health.

SEPTEMBER 2014



Executive Summary

In 1999, the Centers for Disease Control and Prevention (CDC) initiated Racial and Ethnic Approaches to Community Health (REACH) to address the Healthy People 2010 goal of eliminating racial and ethnic health disparities in the U.S. Through the REACH program, six National Organizations that Serve Minority Communities (MNOs) were funded to design and implement health equity projects that would work towards closing the health disparity gap in at least one of the following racial and ethnic minority groups: African American/Black, American Indian/Alaskan Native, Latino/Hispanic American, Asian, and Native Hawaiian or other Pacific Islander. The REACH MNOs focused on reducing disparities in one or more of the following health priority areas: breast and cervical cancer screening and management, cardiovascular disease, diabetes mellitus, tobacco use, and infant mortality. A brief description of each MNO's Health Equity Project is provided below.

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL), with the help of its affiliates and partners, developed the National Asian Pacific Network to Eliminate Health Disparities (NAPNEHD) to reduce cardiovascular disease disparities among Asian Americans, Native Hawaiians, and Pacific Islanders. Focusing particularly on communities in New York City, the Seattle area, and the Pacific nation of Palau, evidence-based information and culturally- and linguistically-specific materials were disseminated over the program's five years.

The **Black Women's Health Imperative**, along with its partners the Center for Black Women's Wellness in Atlanta and South Side Help Center in Chicago, launched the SisterREACH US initiative to explore what is known about breast and cervical cancer inequities experienced by Black women in the areas of research, early detection, timely diagnosis, and access to quality treatment. Through this initiative, the Imperative and its partners advanced the science around effective strategies for eliminating barriers to education, treatment, support, and care for Black women at risk for or living with breast or cervical cancer; and educated decision-makers on the programmatic, health care delivery, funding, and legislative levels to increase understanding of the complexities and challenges Black women face in pursuing health.

The **Inter-Tribal Council of Michigan**, along with two affiliate organizations—Red Star Innovations and Hannahville Indian Community—disseminated evidence-based information and culturally-specific materials about commercial tobacco prevention and control via program websites, newsletters, in-person trainings, webinars, and national conferences. Capacity and knowledge in tribal communities regarding tobacco control and prevention have increased, as shown through evaluations and success stories.

The **Joint Center for Political and Economic Studies** and its PLACE MATTERS teams (local affiliates) built the capacity of communities and leaders to identify and address the social, economic, and environmental conditions that shape health and life opportunities. An integrated communications strategy using both traditional community outreach and social media, implemented over the course of five years, led to policy shifts that address racial disparities in cardiovascular disease, diabetes, and infant mortality in Baltimore, MD, and Bernalillo County, NM.

To address the disproportionate incidence and mortality rates due to cervical cancer among Latinas, the **National Council of La Raza's** (NCLR) Institute for Hispanic Health, with the help of its community-based Affiliate organizations, developed and implemented a culturally competent and linguistically appropriate cervical cancer prevention intervention called *Mujer Sana, Familia Fuerte* (Healthy Woman, Strong Family) in Chicago, IL, and Washington, DC. Statistical analyses have found that *Mujer Sana, Familia Fuerte* has increased knowledge, positive attitudes, self-efficacy, and intent to screen for cervical cancer among Latina community members.

The **Society for Public Health Education's** (SOPHE) Health Equity Project focused on promoting healthy lifestyles to prevent, manage, and delay the onset of diabetes and to reduce the prevalence of risk factors for chronic diseases. The healthy lifestyle interventions concentrated on increased physical activity, improved nutrition, and reduced tobacco use among an African American/Black population in the rural area of Jenkins County, GA and an American Indian/Alaska Native population in the urban area of Oakland, CA. National SOPHE continues to expand the number of its Chapters and their partners who implement evidence-based programs within minority communities.





Chapter One

DATA ON HEALTH DISPARITIES FOR RACIAL AND
ETHNIC MINORITY GROUPS IN THE U.S.

BREAST CANCER—BLACK WOMEN'S HEALTH IMPERATIVE

Breast cancer is the most commonly diagnosed cancer among Black women. While death rates for most cancers have declined overall, racial and ethnic disparities in breast cancer morbidity and mortality continue to persist. For most forms of cancer, including breast cancer, African Americans have both higher death rates and shorter survival periods than any other ethnic group.

A complex mix of economic, social, cultural, biological, and environmental factors has precluded Black women from equally benefiting from the improvements in breast cancer screening and early detection, treatment and survivorship. How these factors contribute individually and collectively to breast cancer morbidity and mortality in Black women is the subject of a growing area of research.

Despite Lower Incidence, Black Women More Likely to Die of Breast Cancer

Since the early 1990s, a steady decline in breast cancer mortality has been reported for all women; however, the death rate among African American women has decreased at a much slower pace. Despite a 10% lower incidence of breast cancer, Black women experience a 33% higher death rate due to the disease than White women.¹

The five-year survival rate for breast cancer diagnosed in 1996–2004 among White women was 90%, compared to only 77% for Black women.² This higher mortality rate is explained by more advanced stage distribution among Black women and poorer stage-specific survival. Yet when survival rates among Black and White women with advanced breast cancer are examined, Black women still fare worse.

In a study of survival rates among 15,538 breast cancer patients from the National Cancer Institute's Surveillance Epidemiology and End Results (SEER) database, researchers found that despite progressively improving survival rates among White women, survival rates for Black women with advanced breast cancer remained stagnant during the same period.³ Survival rates for White women improved from a median of 20 months to 27 months. In contrast, survival rates for Black women remained at a median of 17 months. Researchers, ruling out changes in the biology of the disease, hypothesized that lack of access to health care and to newer modalities for treatment of stage IV breast cancer were contributing factors to the growing disparity.

Other key statistics and facts about Black women and breast cancer include:

- » Incidence rate for breast cancer is lower for Black women (113.4) than it is for White women (123.4).
- » Mortality rate for breast cancer is higher for Black women (33.0) than it is for White women (24.5).
- » Percentage of Black women (24.1%) and White women (24.9%) who have not had a mammogram within the last two years is similar.⁴

Disparities in Access and Treatment

- | | |
|---|--|
| » Unequal access to quality health care | » Lack of data specific to Black women to guide and inform early detection and treatment modalities |
| » Delays in early detection, diagnosis, and treatment | |
| » Inadequate or inappropriate care | » Cuts to programs that provide breast cancer screenings and other services to low-income women |
| » Lack of knowledge specific to Black women's issues | » U.S. Preventive Services Taskforce's recommendation for breast cancer screening mammography to begin at age 50—a death sentence for many Black women who are developing breast cancer before the age of 45 |
| » Limited access to quality mammograms and treatment | |
| » Environmental hazards in our communities | |
| » Racial discrimination/stress | |
| » Lifestyle of women developing breast cancer; living spaces and environments not conducive to healthy living | |

CERVICAL CANCER—NATIONAL COUNCIL OF LA RAZA

Cervical cancer is a preventable disease that is curable when detected early and treated appropriately. Screenings may help significantly to reduce deaths due to cervical cancer; however, Latinas' screening rates remain low,⁵ and they suffer disproportionately from the disease. In 2010, Latinas had the second highest rate of developing and dying from cervical cancer out of all racial and ethnic groups.⁶ Low cervical cancer screening rates among Latinas are associated with barriers such as language, fear, immigration status, embarrassment, lack of knowledge, and lack of health insurance.

This issue is of particular importance in light of Latinos' status as the largest racial/ethnic minority in the U.S., with a population of over 52 million.⁷ By 2050, that number is expected to rise to 132.8 million, while the number of Latinas is expected to double from 15% (2009) to almost 30% of the U.S. female population.⁸

CARDIOVASCULAR DISEASES — ASIAN PACIFIC PARTNERS FOR EMPOWERMENT, ADVOCACY AND LEADERSHIP

Despite common stereotypes of Asian Americans being healthy and having low body-mass indices (BMI), Native Hawaiians and Pacific Islanders (AANHPI) are at greater risk for cardiovascular diseases (CVD) than non-Hispanic Whites, even at lower BMI. A single BMI threshold for widely varying ethnicities fails to capture differences in body fat distribution, leading to the World Health Organization recommendations to lower the BMI thresholds for Asians worldwide.⁹ A national survey of over 90,000 electronic health records found that rates of coronary heart disease were significantly higher for Filipino men and women and Asian Indian men than for non-Hispanic Whites.¹⁰

A lack of disaggregated data frequently means that policymakers and health professionals are mistakenly informed that health disparities among AANHPI populations do not exist. When data for AANHPI ethnic groups is collected and analyzed separately, the wide disparities among them and in contrast to the general population become apparent.

The Journal of Community Health further found that "acculturation to the U.S. is a risk factor for obesity-related behaviors among Asian American adolescents." For foreign-born Asian Americans,

having to navigate necessary acculturation and language acquisition while attempting to preserve healthier foodways and approaches to exercise presents a unique challenge not faced by the mainstream population. For these reasons, Asian Pacific Partners for Empowerment, Advocacy, and Leadership (APPEAL) advocates for culturally competent data, training, research, organizations, and institutions in order to address the disparities faced by our communities.

DIABETES—JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES AND SOCIETY FOR PUBLIC HEALTH EDUCATION

Many racial and ethnic minorities experience higher rates of chronic disease than national averages. Of the underlying factors that contribute to health inequities, some of the most important include socioeconomic inequality and differences in community living conditions. Minorities are far more likely to be consigned to areas of concentrated poverty, where access to healthy foods and places to exercise are sorely lacking. Thus, conditions such as obesity and diabetes are more frequent among residents of poor neighborhoods, making it important to address these conditions through a range of policy strategies focused at the community level.

Diabetes among African Americans and Hispanics

- » African Americans are twice as likely to be diagnosed with diabetes and more likely to have high blood pressure than non-Hispanic Whites, even though they have similar or lower rates of high cholesterol.¹¹
- » In 2010, African Americans were 2.2 times as likely as non-Hispanic Whites to die from diabetes.¹³
- » In 2008, African American men were 2.7 times as likely as non-Hispanic White men to start treatment for end-stage renal disease related to diabetes, and diabetic African Americans were 1.7 times as likely as diabetic Whites to be hospitalized.¹²
- » Hispanics are almost twice as likely as non-Hispanic Whites to be diagnosed with diabetes by a physician.¹⁴
- » In 2008, Hispanics were 1.6 times as likely as non-Hispanic white men to start treatment for end-stage renal disease related to diabetes, and in 2010, they were 1.5 times as likely to die from the disease.¹⁵

DIABETES—JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES AND SOCIETY FOR PUBLIC HEALTH EDUCATION (CONT.)

Problem

Diabetes is the seventh leading cause of death in the United States. In 2010, 18.8 million people were diagnosed with diabetes, while 7 million people were undiagnosed and 79 million were diagnosed with prediabetes, a state which carries a high risk for developing type 2 diabetes.¹⁶ People with prediabetes have blood glucose (sugar) levels that are higher than normal, but not high enough to be classified as diabetes. By 2050, an estimated 48 million U.S. residents are expected to have diagnosed diabetes.¹⁷ Diabetes is a leading cause of kidney failure; new blindness in adults; leg and foot amputations unrelated to injury; heart disease; and stroke.¹⁸

Cost

According to the American Diabetes Association, the total cost of diagnosed diabetes in the United States was \$245 billion in 2010.¹⁹ The average medical expenditure of a person with diagnosed diabetes (\$13,700), of which about \$7,900 is attributed to diabetes, was 2.3 times higher than that of a person without the disease.²⁰ Caring for someone with diabetes accounts for \$1 out of every \$5 spent on health care in the United States.²¹

INFANT MORTALITY—JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES

Communities of color experience higher rates of infant mortality relative to national averages. Many factors contribute to high rates of infant mortality in communities of color, but some of the most important underlying causes are socioeconomic inequality and differences in living conditions. African Americans, for example, have 2.3 times the infant mortality rate of non-Hispanic Whites.²² They are almost four times as likely to die as infants due to complications related to low birthweight as compared to non-Hispanic White infants.²³ Other statistics include:

- » In 2009, African Americans had twice the sudden infant death syndrome mortality rate as non-Hispanic Whites, and African American mothers were 2.3 times more likely than non-Hispanic White mothers to begin prenatal care in the third trimester or to not receive prenatal care at all.²⁴
- » In 2005, the infant mortality rate for African American mothers with over 13 years of education was almost three times that of non-Hispanic White mothers.²⁵
- » Hispanic Americans also have a higher infant mortality rate as compared to non-Hispanic Whites. In 2008, Hispanic mothers were almost twice as likely as non-Hispanic White mothers to begin prenatal care in the third trimester or to not receive prenatal care at all.²⁶

TOBACCO—INTER-TRIBAL COUNCIL OF MICHIGAN, INC.

Smoking is the number one cause of preventable deaths in the United States, killing approximately 480,000 people per year.²⁷ According to the 2014 Surgeon General Report, *The Health Consequences of Smoking—50 Years of Progress*, smoking has been causally linked to diseases of almost every organ of the body, and there is no safe level of cigarette smoke. According to the same report, the financial burden is calculated between \$289–332.5 billion spent annually.

Data collected from 2005 to 2012 show that 18.1% of all adults in the U.S. are current cigarette smokers.²⁸ The data showed American Indian/Alaska Natives had the highest smoking prevalence of all the racial/ethnic groups at 21.8%, while non-Hispanic Asians had the lowest (10.7%). Since many American Indian/Alaska Natives use traditional or sacred tobacco—tobacco without harmful chemicals added—for ceremonial and other cultural uses, mainstream tobacco interventions do not always have a positive impact in tribal communities. Therefore, culturally-tailored information and materials are necessary to reduce the burden of commercial tobacco in tribal communities.





Chapter Two

INTRODUCTION OF REACH MNO

In 1999, the Centers for Disease Control and Prevention (CDC) initiated Racial and Ethnic Approaches to Community Health (REACH) to address the Healthy People 2010 goal of eliminating racial and ethnic health disparities in the U.S. Through the REACH program, 40 communities were funded to close the health disparity gap in at least one of the following racial and ethnic minority groups: African American/Black, American Indian/Alaskan Native, Latino/Hispanic American, Asian, and Native Hawaiian or other Pacific Islander. In addition, communities focused on reducing disparities in the following six health priority areas: breast and cervical cancer screening and management, cardiovascular disease, diabetes mellitus, immunizations, HIV/AIDS, and infant mortality.

REACH supported community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities. Sample community coalition activities included 1) continuing education on culturally appropriate disease prevention interventions for health care providers and the elimination of health care disparities when treating patients of diverse racial and ethnic groups, 2) using lay health workers to deliver health promotion and chronic disease prevention programs to community members,

3) implementation of environmental change strategies that increased access to fresh fruits and vegetables in communities where these commodities were not readily available, and 4) changes in school nutrition policies to insure healthier choices for children.

MNOs are organizations with national reach and local chapters or affiliates that specifically provide health information, training, and technical assistance to one or more of the population groups, and have contributed significantly to the public dissemination of strategies to address chronic and/or infectious diseases throughout the U.S. These organizations have cultivated strengths and expertise that can

augment and expand the impact of the REACH program. MNOs can be especially helpful in the dissemination of evidence-based strategies and tools and the provision of capacity-building technical assistance to local affiliates and chapters, given their longevity and established track record of spurring needed social change among their constituents.

Compelling evidence indicates that race and ethnicity correlate with persistent and often increasing health disparities among U.S. populations, which demand national attention. Actively engaging MNOs in eliminating health disparities can help reverse these persistent patterns.



Chapter Three

REACH MNO COLLABORATIVE EFFORTS

The REACH MNOs believe in collective impact—the commitment of a group of actors to a common agenda for solving a complex social problem. Over the past two years, the six REACH MNOs have collaborated on a number of events. In 2013, the REACH MNOs conducted a panel presentation at the American Public Health Association (APHA) Annual Meeting, during which they discussed the challenges of alleviating disparities in communities of color, how they were able to overcome those challenges, and their successes. The REACH MNOs also convened a Capitol Hill briefing at the request of the Honorable Donna Christensen (D–VI), during which representatives from each organization discussed their approaches to eliminating health inequities.

In March 2014, the REACH MNOs participated in a panel discussion about the REACH program at SOPHE’s 65th Annual Meeting, Discovery 2014: New Health Education Strategies, Connections & Ideas. In April of the same year, during National Minority Health Month, the REACH MNOs hosted a Twitter chat with the theme, “Prevention is Power: Taking Action for Health Equity.” Additional examples of the REACH MNOs’ partnership can be seen below.

2009 Black Women's Health Imperative, Joint Center, and SOPHE met to discuss possible strategies to work together

Each organization confirmed affiliates and chapters to collaborate on their Health Equity Projects

2010 March 10–11: All six REACH MNO organizations participated in the 2010 CDC Technical Assistance (TA) Meeting

Each organization partnered with a Center of Excellence in the Elimination of Disparities (CEED)

2011 March 9–11: Oral and Poster Sessions, CDC/REACH U.S. Meeting—Atlanta, GA

2012 February–August: REACH National Organizations Webinar Series, coordinated by SOPHE—www.sophe.org/REACH-MNO-Webinar-Series.cfm

April 23: CDC Meeting (Oral Session)—Developed fact sheets

2013 March 22: REACH face-to-face quarterly meeting in Washington, DC

August 26–29: CDC TA Meeting

November 2–6: Oral Presentations, APHA Annual Meeting: Think Global Act Local: Best Practices Around the World—Boston, MA

November 13: REACH Hill Briefing on Capitol Hill—Developed fact sheets

2014 March 19–21: Oral Presentation, SOPHE 65th Annual Meeting—Baltimore, MD

April 23: REACH MNO Twitter Chat, "Prevention is Power: Taking Action for Health Equity"—1.8 million impressions

September: Publication of REACH MNO: Success Stories Booklet

Ongoing ITCM serves on the SOPHE Minority Communities Advisory Committee

REACH MNOs have attended each other's dissemination activities (conferences, meetings, briefings)

Black Women's Health Imperative and ITCM have served as guest speakers for the SOPHE Competency-Based Technical Assistance Curriculum



REACH Minority Organizations Twitter Chat #REACHMNO

Date range

Apr 23 - Apr 23

304

posts

75

users

557,970

reach

1,874,231

impressions

Top Posts

RTs Klout Recent

Tip: Click on a tweet's date to be taken to original post

- | | | | |
|---|--|---------|--|
|  |  Candace Montague @urbanbushwoman9 | 1:30 pm |  21 |
| Black women are two times more likely to die from cervical cancer. Regular pap smear tests can lower that rate. #REACHMNO | | | |
|  |  NCLR @NCLR | 1:03 pm |  11 |
| A1: Eliminating racial and ethnic disparities gives everyone an equal chance to achieve optimal health. #latinohealth #REACHMNO #NMHM14 | | | |
|  |  NCLR @NCLR | 1:12 pm |  9 |
| A2: We work with 2 CBOs that help us spread the word about cervical cancer disparities & how we can change them. #latinohealth #REACHMNO | | | |
|  |  Brian Smedley @BrianDSmedley | 1:16 pm |  8 |
| @JointCenter #REACHMNO Strong community partnerships are critical, including stakeholders from all sectors - faith groups, businesses, CBOs | | | |





Chapter Four

IMPACT OF COLLABORATIVE AND UNIQUE
ORGANIZATIONAL EFFORTS

Community-based partnerships and asset-based community development allow positive relationships to be built between organizations and the community. Community-based partnerships allow organizational representatives and community members to actively collaborate, enhancing and integrating the knowledge gained through partner expertise to benefit the community. Asset-based community development allows these community-based partnerships to empower the community members to create and implement their own visions, leading to a stronger level of sustainability within the community.

In order to establish an impactful partnership, good organization and communication are essential. Through REACH MNO affiliates, a yearly action plan is created to evaluate, reassess, allocate, and leverage national resources.

Meanwhile, throughout the course of the year, affiliates and chapters meet regularly and provide capacity-building technical assistance and training to support REACH communities. They also convene with their local affiliates and chapters to assess needs with respect to their role, tools, and available resources. These summits facilitate effective organization and communication towards the ultimate goal of ending health disparities.

Subsequently, building relationships such as these allows the community to grow stronger and more self-reliant. A new set of expectations will begin to form, heightening problem-solving competency and the capacity for self-direction. Gradually, as the web of ties among assets is reconstructed, the need for outside guidance diminishes and the dissemination of evidence-based strategies is completed.

EFFECTIVE AND SCALABLE NETWORK MODEL

Diffusion of innovation is a valuable change model that relies on the process of evolution as ideas, practices, products, and philosophy become adopted within the community. It stresses the importance of peer networking and communication among five categories of adopters: innovators, early adopters, early majority, late majority, and laggards. The adoption process begins with a small group of visionary, venturesome innovators who actively seek out information and act as the gatekeepers for the early adopters. Once the early adopters accept the innovation, it spreads on to the early majority and late majority, both of which hold a greater part of the overall categories. The Diffusion of Innovation ends with a small group of laggards, who are more reserved in adopting the change. The

goal of the Diffusion of Innovation model is not to persuade individuals to change, but to streamline the innovation to meet the needs of all five categories.

The rate at which this innovation is adopted is the relative speed with which an innovation is adapted by members of a social system. This adaptation is done through five stages: awareness, interest, evaluation, trial and adoption. The more peer-to-peer communication, role modeling, and networking done through coalition development and mass media, the quicker the rate at which innovation is adopted.

CULTURAL COMPETENCIES OUTREACH

According to the Office of Minority Health, cultural competency involves providing services in a manner that respects differences in culture, race, ethnic background, or religion, particularly as they relate to health practices. Other considerations include geographic location, population density, rates of in- and out-migration, age distribution, and social, political, and economic climates (National Center for Cultural Competence). The concept of cultural competence helps plan health services that are practical for providers, appealing to the targeted audience, and that improve health outcomes. Providing culturally competent care can also help to reduce health disparities. By prioritizing cultural competency in hiring, grant-making, and program development, organizations can ensure that their efforts will reach their intended audiences and be effective.

REACH MNOs have used the concept of cultural competency in designing and implementing their interventions in diverse communities. The REACH MNOs have prioritized working with partners and sub-grantees deeply rooted in the communities they serve. We believe that their relationships and experience make them the best possible conduits for the evidence-based public health information we are focused on disseminating. At the same time, our work presents multiple opportunities for increasing cultural competency among the mainstream population. Public health officials, hospital staff, nonprofits administrators, doctors, teachers, and other professionals working in impacted communities are welcome and encouraged to attend our events and use our publications. The collective knowledge of the REACH MNO grantees provides a solid base of survey data and best practices to improve health outcomes across the entire population.





Chapter Five

REACH MNO HEALTH EQUITY PROJECTS



ASIAN PACIFIC PARTNERS FOR EMPOWERMENT, ADVOCACY, AND LEADERSHIP

BACKGROUND INFORMATION

Cardiovascular disease (CVD) is one of the leading causes of death in Asian American, Native Hawaiian, and Pacific Islander communities (National Center for Health Statistics, 2011). Behavioral risk factors associated with this disease can be linked specifically to smoking, physical inactivity, and poor nutrition.²

Recognizing the importance of fostering healthier lifestyle choices within these priority populations, APPEAL began the National Asian American and Pacific Islander Network to Eliminate Health Disparities (NAPNEHD) in October 2009, with the goal of eliminating health disparities in these communities by focusing on environmental and policy change.

The objectives of NAPNEHD are to:

- » Develop, implement, and refine a strategic plan for eliminating health disparities with affiliate partners and other key stakeholders.
- » Facilitate and strengthen a learning community that fosters the sharing of information and collaboration throughout the NAPNEHD and the AA and NHPI communities.
- » Enhance the capacity of the local NAPNEHD affiliates to reduce health disparities through policy change using the APPEAL Policy Change model.
- » Provide community competent and relevant technical assistance, training, and leadership development for the NAPNEHD affiliates and the larger AA and NHPI communities.
- » Document and disseminate progress and performance of the NAPNEHD .

Partners

Our two affiliate partners are:

- » The Coalition for Asian American Children and Families (New York)
- » Coalition for a Tobacco Free Palau (Palau)

ACCOMPLISHMENTS AND TIME COMMITMENT

APPEAL has defined community capacity as a community's current (as opposed to inherent) ability to respond to certain pressures. When looking at the impact of CVD on communities, one must look not only at the clinical data and physical access features (such as grocery stores and walking trails) but also at the capacity of a community to advocate for itself and leverage culturally competent solutions. APPEAL's Stages of Readiness Model was developed with the knowledge that many AA and NHPI communities, particularly those facing critical poverty or consisting primarily of new immigrants, may not be ready to address CVD in the same manner that other more established communities are able to.

At the same time, APPEAL is focused on parity by ensuring that AA and NHPI voices are included in mainstream anti-obesity and CVD abatement discussions. As part of its Health Equity Project, APPEAL and partner organizations attended a range of events and groups aimed at improving food access and built environment, including: NYC Mayoral Forum on Food, Active Living Research Annual Conference, Kellogg Food and Community Gathering, and the APHA Annual Meeting. Often, we were among the very few Asian American or Pacific Islander equity groups in the room.

Our accomplishments include:

- » In the first two years of this project, 373,920 individuals were reached in the three geographic areas of the affiliates: Republic of Palau, New York City, and Washington State.
- » Email list reaches 265 network members, most of whom are administrators or leaders of their own networks. As a result, monthly Healthy Eating/Active Living (HEAL) subcommittee updates (with reports, funding opportunities, new research, and events) reach between 1000–5000 active community members.
- » Under NAPNEHD's mentorship and with the goal of making it easier for communities to live healthily, regional partners have gotten increasingly involved in:
 - Built environment improvements, including complete streets and play streets
 - School lunch access
 - Community policy change (soda-free community events, for example)
 - Coalition-building (bringing in other organizations to work on shared goals in healthy eating and active living)

Success Story

BUILDING COMMUNITY CAPACITY FOR POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGE IN AANHPI COMMUNITIES

By Nina Ichikawa

SUMMARY

Asian Americans are at a higher risk of weight-related health issues at a lower body mass index than other ethnic groups. Other health disparities exist among this population, as well: Asian Indians in Ohio, for example, have coronary artery disease prevalence rates four times that of the general U.S. population. National Asian American and Pacific Islander Network to Eliminate Health Disparities (NAPNEHD) leadership training prepares community leaders to identify trends like these, share them with constituents, and use them to improve the public health environment.



CHALLENGE

Among Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities, there is often a lack of indigenous leadership for public health data gathering and advocacy. AANHPIs are underrepresented in public health departments, nonprofit organizations, and advocacy groups. We need to both build our communities' capacity and press for equitable representation in multi-sector partnerships. It's often challenging for groups representing a diverse, multilingual AANHPI constituency to mobilize forces and implement evidence-based strategies to combat non-communicable diseases on a large scale.

RESULTS

NAPNEHD has held multiple trainings from 2009 to 2014 to develop future and current leaders in AANHPI communities. The APPEAL Policy Summit, held in San Francisco, in 2013, gave NAPNEHD the opportunity to present on Food Policy Considerations for AANHPI communities. Multiple partnerships and collaborations were formed to promote the "Good Eats, Safe Streets" campaign — a program to promote environmental change toward providing access to healthy food and active lifestyles for AANHPI communities — during July 2014. Informational and educational materials have been developed for dissemination among these communities and promoted through our partner organizations throughout the nation and the Pacific Islands.

SOLUTION

NAPNEHD was created to address these challenges, partially by building community capacity for long-term leadership in the public health arena. It follows the leadership training structure developed by the Asian Pacific Partners for Empowerment, Advocacy & Leadership (APPEAL) in 1997. NAPNEHD focuses on building competencies in collaboration, advocacy, equity building, systems navigation, and healthy eating and active living content areas.

SUSTAINABLE SUCCESS

Lessons learned from the APPEAL Leadership Model include:

1. Leadership development can build community capacity to engage in tobacco control and other social justice and health equity issues;
2. Leadership development can result in powerful policy and systems change; and
3. Leadership trainings can be adapted to any social justice issue and any marginalized community including cross-cultural groups.

With the lessons learned and the successes of the different leadership trainings, NAPNEHD has developed valuable materials for dissemination to increase awareness around the disparities faced by AANHPI communities. To sustain the success of these efforts, future funding will be needed to continue the work and partnerships established from NAPNEHD.

YOUR INVOLVEMENT IS KEY

To get involved with the work of NAPNEHD and APPEAL:

Attend a conference, meeting, or event held by APPEAL

Participate in a webinar sponsored by NAPNEHD and APPEAL

Join the APPEAL Network and receive our regular communications

Request informational and educational materials from APPEAL for your organization or for dissemination

To learn more about NAPNEHD and APPEAL:

Go to www.appealforhealth.org

Join the network at:

www.appealforhealth.org

Follow on Twitter at:

twitter.com/appealhealth

Follow on Facebook at:

facebook.com/appealforhealth

Contact

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APPEAL

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<http://www.appealforhealth.org>

“Great job, quality summit. Very rich experience. I am looking forward to collaborating more intentionally with the AAPI and NH communities in my region.”

— SF Policy Summit 2013 Attendee

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) is a national health justice organization working to achieve health equity for Asian Americans, Native Hawaiians, Pacific Islanders and other underserved communities.

Lessons Learned

One of the biggest lessons learned is the need for disaggregated data on CVD disparities in the AANHPI community. Because there are multiple risk factors for CVD, and multiple ethnic communities, each one deserves research and analysis. Having this culturally specific data, with some collected from non-English speaking respondents, would help us both reach our communities more effectively and explain the problem to others.

Another lesson learned was the importance of building relationships to strengthen our network. With staff turnover and changing requirements, our network at times suffered. We are learning ways to both support staff to create long-term bonds with the community, and use technology solutions like automated email list software and cloud computing in order to maintain continuity of information and relationships.

Finally, our network affiliates learned a great deal about local implementation in the course of this grant. For example, Coalition for Asian American Children and Families (CACF) in New York City began the grant period with great enthusiasm for community gardening. Along with the five members of APA HEALIN' (their healthy eating and active living consortium), they engaged in a photo-voice research project on food, health, and built environment in communities where AANHPI New Yorkers live and work. The result was an excellent report, "Planting Seeds of Change: Strategies for Engaging Asian Pacific Americans in Healthy Eating and Active Living Initiatives," published by CACF in May 2012. The background research generated by community participatory research has been a valuable tool in the years since. However, the extremely high cost of public land in New York, population density, and continuing land-use battles for community gardens have meant that their plans for AANHPI food access gardens have not come to fruition. What we learned from this was that community-led research also needs realistic assessments regarding the real estate, financial, and legal environment in order to proceed successfully.

Resources

NAPNEHD Webinars (all available at <http://appealforhealth.org/presentations>):

- | | | |
|---|---|--|
| » "Foundational Skills of Public Health: Organizational Capacity & Partnership Development for Health Equity" | » "Creating a Healthy Eating Active Living Movement for Asian Americans, Native Hawaiians, and Pacific Islanders" | » "Building Communities Around Healthy and Responsible Food: Ma'o Organic Farms" |
|---|---|--|

Find more factsheets, data, videos, and other resources at <http://appealforhealth.org> under "Resources."



BLACK WOMEN'S HEALTH IMPERATIVE

BACKGROUND INFORMATION

For the past three decades, the Imperative has served as the leading voice for health and wellness for Black women and girls across the country. We provide evidence-based solutions that combine health advocacy, health education, and programs to eliminate barriers and ensure that every Black woman can achieve her optimal health—physically, emotionally, and financially. We invest in programs and partnerships that improve Black women's lives, families, and communities.

Founded in 1983 as the Black Women's Health Project, the Black Women's Health Imperative is a nonprofit, nonpartisan 501(c)(3) organization located in Washington, DC. Today, we continue in our mission to advance health equity and social justice for Black women across the lifespan, to eliminate racial and gender-based health inequities, and to deepen Black women's resolve in becoming informed decision-makers to achieve optimum health and wellness.

Advocacy and Public Policy: We advocate for policies that protect women's human rights and support a woman's decision-making and choices. Our advocacy efforts move us beyond documenting the enormous health disparities that exist for Black women to focusing on actionable steps to eliminate the health inequities they face. Operating within a reproductive justice framework, our work underscores how inequalities and complexities in Black women's lives profoundly impact their reproductive choices, rights, and health care decision-making. Through advocacy and public policy, we place Black women and their lived experiences at the forefront and expose the conditions and systems that impinge on reproductive autonomy.

Education and Training: Our education initiatives provide Black women with the information, tools, and resources that help them become informed and empowered health care consumers and caregivers. Operating within a self-care framework, our strategies provide opportunities for Black women to actively pursue wellness and lend support to each other in making informed health care decisions. Our aim is to increase awareness of the actions and decisions Black women can make to avoid or reduce their risk of developing preventable health conditions and their potentially long-term complications, while helping them embrace emotional wellness as part of their overall health.

Leadership Development: Our leadership development programs are health empowerment models supported by evidence and practice-based curricula. All training and leadership programs are designed to enhance the competencies and skills of Black women and organizations to become part of a network of national and community leaders who work together to champion our causes of health equity, quality health care, and reproductive justice for all.

Research: The Imperative strives to be widely recognized and highly regarded as the credible information source on all issues related to Black women's health. We achieve this goal through both secondary and qualitative research activities. By compiling, examining, interpreting, and reporting relevant research on the status of Black women's health, we can effectively build and share a solid knowledge base of health issues impacting Black women. We also actively and aggressively promote inclusion of Black women's health issues as a research priority at the national and federal levels.

ACCOMPLISHMENTS AND TIME COMMITMENT

The Imperative's health equity initiative, SisterREACH US, integrates culturally appropriate and gender-specific elements into community-driven strategies that address the breast and cervical cancer disparities and inequities that exist among Black women. Though our work with two community-based partner organizations—South Side Help Center in Chicago and Center for Black Women's Wellness in Atlanta—we address the social determinants that contribute to the growing health disparities experienced by Black women, implement strategies based on the most promising evidence-based and/or community-focused interventions, disseminate information, facts, strategies, and resources aligned with addressing health inequities and bringing about local systems change.

Key impacts of our work have included:

Enhanced understanding of the issues by:

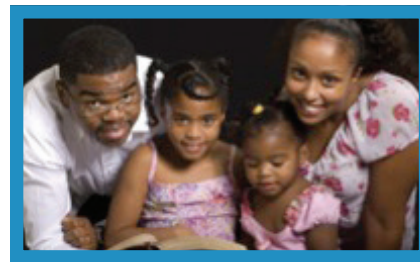
- » Promoting our "3-D" campaign messages—Detect. Diagnose. Decide.
- » Educating and encouraging women to conduct breast self-exams
- » Educating legislators on concerns and issues faced by Black women—amplifying their voices
- » Supporting women in becoming informed participants

Community members educated on Affordable Care Act (ACA) benefits:

- » The ACA provides several benefits that can improve Black women's breast cancer outcomes:
 - Mammography and well woman exams (including clinical breast exams) without a co-pay
 - Medicaid expansion and access to affordable coverage through exchanges
 - Insurance plans will cover BRCA1 and BRCA2 testing for qualified women

Success Story

SISTERREACH US: MOVING BEYOND PINK TO END BREAST CANCER DISPARITIES



By: Valerie Rochester

SUMMARY

With our partners, Black Women's Health Imperative is working to "move beyond pink" and enhance understanding of what is needed to address the inequities in breast health experienced by Black women. We are encouraging and educating women to take control of their breast health and supporting them in becoming informed and educated participants in their health care. We are also educating decision-makers on the concerns and issues Black women face related to breast cancer.

CHALLENGE

- » Breast cancer is the most commonly diagnosed cancer among Black women.
- » The overall downward trend in breast cancer mortality has been attributed to advances in early detection and treatment; however, it is not clear whether these advances have translated to better outcomes for Black women. Black women are more likely to have breast cancer diagnosed at advanced stages.
- » A complex mix of economic, social, cultural, biological and environmental factors has precluded Black women from equally benefiting from the improvements in breast cancer screening and early detection, treatment, and survivorship.

SOLUTION

The way forward in eliminating breast cancer disparities is to challenge the status quo by seeking improved screening and assessment options, better standards for treatment and care, and targeted research funding. Although still not fully understood, there are many environmental, political, and economic factors that place Black women at increased risk. The Imperative is addressing these issues by: providing lay health education on breast and cervical cancer and the importance of screening, early detection, timely diagnosis, and quality treatment; assessing patient navigation issues among Black women in need of education, social support, and treatment; providing referrals for breast and cervical cancer screenings; and engaging local decision-makers in efforts to bring about systems change to address breast cancer disparities.

RESULTS

- » Through our work with our partner organizations, we have been able to:
- » Increase access to mammography by supporting the establishment of two digital mammography sites
- » Implement interventions that inform providers of barriers Black women face in accessing care and that heighten cultural sensitivity among providers
- » Reach over 960,000 women with culturally appropriate educational materials focused on promoting early detection of breast cancer.
- » Launch “Moving Beyond Pink to End Breast Cancer Disparities” campaign promoting the key messages “Detect. Diagnose. Decide” and the importance of early detection
- » Produce “Take Five for Your Health” breast self-exam shower cards

SUSTAINABLE SUCCESS

The Imperative is committed to continuing our work to improve breast health outcomes for Black women. We have strengthened the role of partner organizations to be viable change-agents in their communities; increased community engagement with the establishment of multi-sector coalitions to address health disparities; and enhanced programming by integrating our proven strategies and interventions into existing community-level programs and services in our target cities.

“To address breast cancer disparities, we must support increased access to the latest screening technologies starting at age 40 or younger; understand and apply improved risk assessments; provide better treatment options; and offer patient support throughout diagnosis and treatment.”

—Linda Blount, President & CEO, Black Women's Health Imperative

YOUR INVOLVEMENT IS KEY

It is important for us all to know we can play a role in reducing the impact of breast cancer in our communities. Visit the Imperative's website at www.bwhi.org to learn how you can help educate women on the importance of early detection, timely diagnosis, and making informed choices about their overall health and health care.

Contact

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Resources

- » "Moving Beyond Pink to End Breast Cancer Disparities" campaign:
<http://www.bwhi.org/moving-beyond-pink/mbphome/>
- » "Myths, Misunderstandings, and the Truth" webinar series:
<http://www.bwhi.org/template-news/podcasts/>
 - Black Women & Breast Cancer: Fact or Fiction
 - Cervical Cancer: A Preventable Silent Killer
 - The Truth About the HPV Vaccine
 - The Future of Breast Cancer Care: Promises and Pitfalls of Personalized Medicine
 - HPV and Black Males palm card—www.bwhi.org

For more information and resources, visit www.bwhi.org.

Lessons Learned

For partnership and community engagement

- » When developing collaborative relationships or partnerships for project implementation, partners must have an organizational vision and values in alignment with those of your organization
- » Be aware and respectful of decision-making processes within community organizations
- » To ensure success in the recruitment and participation of program beneficiaries, engage agencies and organizations that are familiar environments for those you are seeking to reach, i.e. where women already felt connected
- » Understand and practice community competency when being invited in to work in communities
- » When engaging community members, it is important to promote linkages between the individual and larger social forces in the community that are impacting their lives

For effective project implementation

- » Provide opportunities for project partners and participants to become knowledgeable health advocates
- » Offer supportive structures that allow for exploration and application of personal issues and experiences when identifying best practices and evidence-based models
- » When selecting interventions, it is important to link the selected interventions with enhancements in self-concept and self-efficacy
- » Be respectful of the “lived lives” of the persons you are reaching
- » Amplify the voices of those we serve to shift public perception and policies for social change
- » Promote evidence- and practice-based wellness and lifestyle balance models that provide strategies for individuals, families, and communities to address health inequities and become involved in social change
- » Synthesize, translate, and disseminate information and research findings to strengthen understanding and build the knowledge base around what works



INTER-TRIBAL COUNCIL OF MICHIGAN

BACKGROUND INFORMATION

The Inter-Tribal Council of Michigan (ITCM) is a 501(c)(3) nonprofit tribally designated consortium and has been in existence since 1966. The ITCM's Health Education and Chronic Disease Department manages an array of health promotion and disease prevention programs that involve local and national partners. Our REACH MNO project, entitled A PROMISE Partnership, works with two affiliate organizations—Red Star Innovations of Arizona and Hannahville Indian Community of Michigan—to reduce the burden of commercial tobacco use in tribal communities by building capacity and disseminating best and promising practices that integrate commercial tobacco prevention and control and chronic disease programming.

ACCOMPLISHMENTS AND TIME COMMITMENT

- » Basic Tobacco Intervention Skills Certification for Native Communities curriculum developed by the University of Arizona HealthCare Partnership was disseminated in local communities and at our national workshop. Major topics covered in this certification program include: The Five A's Model, tobacco dependence and treatment, tobacco and culture, motivational interviewing, and two skills demonstration activities. The population served by those who attended the trainings is over 350,000 people.
- » National workshop was conducted in Tempe, AZ, in May of 2012. We had over 150 participants representing local communities, tribal organizations, and national organizations. Sessions covered the following topics: program evaluation, creating partnerships, tools, and trainings, smoke-free housing, creating and sustaining employee wellness programs, chronic disease and Alaska Native tobacco use data, tribal governance to promote healthy communities, traditional tobacco, and the integration of traditional and western medicine.

- » Wellness Advisory Council (WAC) was created and sustained in a Michigan Upper Peninsula Tribe. The WAC is based on the community-based participatory research model. High school students and elders were invited to participate in the WAC and assisted with the project at the local level in many ways, including promoting activities through word-of-mouth, playing a key role in the local media campaign with the school system, and providing insight and feedback on the overall project.
- » A local media campaign was carried out by one of our affiliate organizations, Hannahville Indian Community. This included a partnership with the local school system and assistance from the WAC. Students participated in an art contest where they drew pictures against the use of commercial tobacco. A school assembly was held to discuss the dangers of using commercial tobacco, and the winners of the contest were announced. A billboard was created with pictures from one of the classes, and a calendar was created and disseminated with selected artwork from the other classes.
- » The partnerships created in our program helped to disseminate best and promising practices and to increase capacity. We worked with the University of Arizona HealthCare Partnership program, the Arizona quitline, National Native Network, Inter-Tribal Council of Arizona, Michigan Department of Community Health, Health Education and Promotions Council, and the Native American Cancer Research group. The CDC also assisted us throughout the project period to ensure successful completion of project activities.
- » A website was created for A PROMISE Partnership to disseminate information on a national level. Resources and information for Native communities regarding commercial tobacco use are highlighted on the website.
- » Newsletters were created and disseminated to Michigan tribes and via the National Native Network. Topics included in the newsletters: featured best practice, information about commercial tobacco and chronic disease, featured program, and resource section.
- » Seven digital stories were created by local tribal members and disseminated via the program website, ITCM, Red Star Innovations, and the National Native Network. Topics covered by these digital stories include the implementation of the Basic Tobacco Intervention Skills for Native Communities program and secondhand smoke.
- » 1 Principal Investigator, 1 FTE Program Manager, 1 Administrative Assistant, 2 Program Coordinators (work directly in the communities).

Success Story

NATIONAL AND COMMUNITY PARTNERSHIPS TO REDUCE COMMERCIAL TOBACCO USE IN U.S. TRIBES

by: Stephanie Bliss

SUMMARY

The Inter-Tribal Council of Michigan, in partnership with the following affiliate and other organizations—University of Arizona HealthCare Partnership, National Native Network, Inter-Tribal Council of Arizona, Society for Public Health Education, Pascua Yaqui Tribe, and San Carlos Apache Nation—has reached over 350,000 people living in tribal communities with its A PROMISE Partnership tobacco control and prevention project. Capacity and knowledge in tribal communities regarding tobacco control and prevention have increased, as shown in evaluations and success stories. In addition, we were able to create and disseminate culturally-specific materials that will sustain our work well after our program has ended.



CHALLENGE

There are 566 federally recognized tribes, which are sovereign nations, in the United States today. Many tribes are facing disproportionate rates of chronic diseases and suffer from high rates of tobacco use. In addition, many tribes use a non-addictive form of tobacco in ceremonies, prayers, and for other cultural reasons, making mainstream tobacco interventions at times inappropriate for tribal communities. Meanwhile, smoking is the number one cause of preventable deaths in the U.S., killing approximately 480,000 people per year. According to the 2011 National Health Interview Survey, American Indian/Alaska Natives had the highest smoking prevalence of all the racial/ethnic groups at 21.8%. Also reported, 17.8% of American Indian/Alaska Natives smoked during pregnancy, compared to 13.9% of non-Hispanic white women.

SOLUTION

The Inter-Tribal Council of Michigan worked with two affiliate organizations, Red Star Innovations and Hannahville Indian Community, to create and sustain partnerships, build capacity, and disseminate evidence-based information. We formed ongoing partnerships with non-funded entities to increase the reach of our program. We certified health care workers using the University of Arizona HealthCare Partnership's Basic Tobacco Intervention Skills for Native Communities Certification Program, held a technical assistance workshop with over 150 participants, assisted with the implementation for systems change in three tribes, and created and disseminated many culturally-specific materials.

RESULTS

This project has reduced the burden of commercial tobacco use in native communities across the U.S. We disseminated evidence-based information to over 350,000 people by the following methods: certification programs, national workshop, newsletters, digital stories, media campaign, social media, and websites. We increased the skills and knowledge of over 70 health care staff using the University of Arizona HealthCare Partnership's Basic Tobacco Intervention Skills Certification for Native Communities curriculum. Our national workshop was attended by over 150 participants and garnered positive reviews. At the local level, we worked to create and sustain a Wellness Advisory Council that helped to disseminate information throughout the community and to guide project activities, including an anti-smoking art contest with a nearby school. A billboard and calendars were created with the school's artwork and distributed throughout the community. A member of the Wellness Advisory Council said of the art contest, "It was one of the most rewarding experiences that I have had, because I know that if we changed one child's mind during the process, we may have literally saved a life."

SUSTAINING SUCCESS

A PROMISE Partnership's program goal is to reduce the burden of commercial tobacco use in tribal communities by disseminating best and promising practices that integrate commercial tobacco prevention and control with chronic disease programming. We achieved our goal by creating and sustaining partnerships both locally and nationally, disseminating evidence-based information via multiple websites and newsletters, and building capacity in tribal communities through trainings and other activities. To sustain our successes we trained over 70 health care employees in basic tobacco interventions skills, created and disseminated culturally-tailored materials, and created long-lasting partnerships.

YOUR INVOLVEMENT IS KEY

You can assist in reducing the burden of commercial tobacco use in tribal communities. There are over 566 federally-recognized tribes in the United States. Partnering with local tribes or tribal organizations is an important way to improve the health of our country as a whole. Look for tribal communities or organizations near you or ones that are working towards reducing the use of commercial tobacco, and start building a relationship with them.

Contact

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“The University of Arizona HealthCare Partnership was pleased to help actualize the objectives of the Inter-Tribal Council of Michigan’s project. Evaluations received from the REACH project indicate that community health leaders who earned certification along with continuing education credits in the Basic Tobacco Intervention Skills Certification for Native Communities increased their confidence to deliver brief tobacco dependence interventions specific to Native people.”

— Louise J. Strayer, Director, University of Arizona
HealthCare Partnership

Lessons Learned

- » The use of traditional tobacco in ceremonies and other significant events is part of the American Indian culture.
- » Each federally recognized tribe is a sovereign nation; therefore, adopting systems and environmental changes works differently for each of the 566 federally recognized tribes.
- » Community members are more willing to participate in programs if the person leading the program is from the local community.
- » Trust and relationship-building take time—listening is more important than talking.

Resources

- » Digital Stories:
www.itcml.org/departments/health-education-and-chronic-disease/reach-mno/
- » Program website:
<http://www.apromisepartnership.org/>
- » Other resources, including program newsletters:
<http://www.keepitsacred.org/network/>



JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES

BACKGROUND INFORMATION

Founded in 1970, the Joint Center for Political and Economic Studies is one of the nation's leading research and public policy institutions and the only one whose work focuses exclusively on social justice issues of particular concern to African Americans and other communities of color. The Joint Center's Health Policy Institute (HPI), established in 2002, addresses social determinants of health through a focus on empowering communities and improving community characteristics that shape health.

Many racial and ethnic minorities experience poorer health relative to national averages from birth to death, in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. Among the most important underlying causes of these health disparities are socioeconomic inequality and differences in community living conditions. Begun in 2005, HPI's PLACE MATTERS is a national initiative designed to build the capacity of leaders in 27 jurisdictions to identify and address social, economic, and environmental conditions that shape health and life opportunities.

Through the CDC REACH MNO initiative, the Joint Center and its PLACE MATTERS teams are implementing an internet strategies project in Baltimore, MD, and Bernalillo County, NM, to reduce inequities in cardiovascular disease, infant mortality, and diabetes by improving neighborhood conditions for health. The project involves disseminating information, harnessing data to document neighborhood conditions that shape health, and sharing evidence-based practices. Throughout the project, the teams have documented the distribution of health risks and resources within their communities through internet-based mapping tools, have provided opportunities for community members to express their concerns through community meetings and online photovoice and video content, and have disseminated information through their websites and social media outlets.

ACCOMPLISHMENTS AND TIME COMMITMENT

The Joint Center has had great success in reaching the community with its PLACE MATTERS teams in Bernalillo County and Baltimore City and in disseminating information on eliminating health disparities. Combined they have reached over 2 million people. The two local PLACE MATTERS affiliates were able to share best practices and strategies with other community leaders at three events each year, including two learning labs called ACTION Labs, and the PLACE MATTERS National Conference. The internet strategies project helped bolster the reach of the PLACE MATTERS community, which includes 19 teams in 27 jurisdictions across the country.

The Bernalillo County PLACE MATTERS team has developed and nurtured numerous partnerships to help engage the community. The team has cultivated relationships with local neighborhood associations, including Mountain View Neighborhood Association, the Bernalillo Community Health Council, and the International District Healthy Communities Coalition. The team was often called upon to present information at varying venues, most recently at the New Mexico Public Health Association Conference. In addition, the team is part of a New Mexico Statewide Coalition that convenes to address the health disparities.

The team implemented a three-fold communications strategy that included social media platforms, traditional community outreach, and text messaging. The team has used internet strategies to engage the community with tools such as Facebook, Twitter, blogging, interactive mapping, and infographics. One such infographic featured information about local farmers markets in Bernalillo County which provide access to healthier food choices. The team also implemented a text messaging system to share information about upcoming community meetings, called charlas ("talks"). The three forms of outreach—social media, traditional outreach, and text messaging—have interplayed with each other, thereby increasing their reach. The team's success has allowed them to build on their work, cultivating resources to conduct Health Impact Assessments (HIA) in different neighborhoods. The team conducted an HIA in the Mountain View neighborhood of Albuquerque to assess its accessibility and safety, two factors which can impact one's ability to be physically active. The team was also trained by an epidemiologist and mapping expert to recreate and update a map entitled "Infant Mortality by Race Ethnicity, Small Areas, 2002–2011" for the entire state of NM, with the ability to be sorted by cause, race, and increase/decrease of rates. This valuable new skill will help the team update maps for cardiovascular disease and infant mortality.

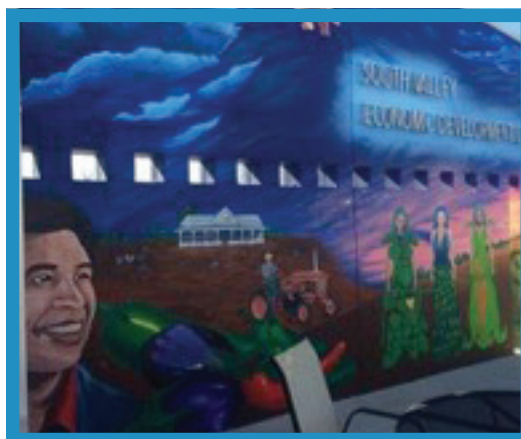
The Baltimore PLACE MATTERS team has also made an impact by rooting themselves in the community and disseminating information on health disparities through social media platforms and their website. The team has emphasized the role that social determinants of health, such as housing and education, play in health outcomes, which has enabled them to collaborate with unique partners. In addition, they have used non-traditional means of outreach, including engaging youth and participating in regular radio show segments to increase their reach. They trained Baltimore Youth Initiative High School students to go out into the community, ask community members about their concerns and what could be improved, and videotape their responses. The students seamlessly integrated with the Baltimore PLACE MATTERS team and helped post information on the team's social media platforms. The team has collaborated with educational institutions including John Hopkins University, University of Maryland, and Morgan State University, as well as with community organizations such as the Druid Heights Community Center and the Park Heights Community Health Alliance. The team's unique collaborations are a reflection of their diverse team members, with representatives from the education sector to the Baltimore Mayor's Office on Criminal Justice.

Success Story

PLACE MATTERS FOR HEALTH: USING INTERNET TOOLS TO REDUCE HEALTH INEQUITIES

SUMMARY

The Joint Center for Political and Economic Studies and one of its local affiliates the Bernalillo County (New Mexico) PLACE MATTERS team, implemented an Internet Strategies Project over the course of five years that led to policy shifts around racial disparities in cardiovascular disease, diabetes, and infant mortality in Bernalillo County, NM. The project combined the use of a variety of Internet tools as well as an integrated communications strategy using traditional media outreach, social media, and text messaging to ultimately reach almost 2 million people.



CHALLENGE

In Bernalillo County, people living in neighborhoods characterized by inadequate schools, poor housing, polluted environments, insufficient transportation, and lack of safety have a lower life expectancy than people living in neighborhoods that don't suffer from such negative characteristics. In addition, the communities that have higher rates of chronic disease have a larger percentage of low-income, immigrant, and Hispanic families than communities that face the fewest health risks. In Bernalillo County, there is:

- » More than a 22-year difference in life expectancy across census tracts;
- » A 12-fold difference in the percentage of low birth-weight infants across census tracts; and
- » A higher concentration of environmental health hazards—such as air pollution and toxic industrial wastes—in non-White and low-income census tracts than in Whiter and higher-income tracts.

SOLUTION

The Joint Center and BC PLACE MATTERS teams attempted to reduce chronic disease inequities by improving neighborhood conditions for health in Bernalillo County. Through the CDC's Racial and Ethnic Approaches to Health (REACH) initiative, they disseminated information, harnessed data to document neighborhood conditions that shape health, and shared evidence-based practices. Internet tools were essential to this project, allowing team members to document the distribution of health risks and resources through mapping tools, provide opportunities for community members to express their concerns through video content, and disseminate information through their website and social media outlets.

RESULTS

Through their internet strategies project, the Joint Center and the BC PLACE MATTERS team reached over 2 million people. They also:

- » Built the capacity of local leaders to address the social, economic, and environmental conditions that shape health;
- » Engaged communities at bi-monthly meetings called charlas ("talks") to identify and advocate for community-based strategies to address health disparities;
- » Supported and informed efforts to establish data-driven strategies and data-based outcomes to measure progress by mapping state data on infant mortality, CVD, and diabetes and sharing it with the community; and
- » Shared successes with their national PLACE MATTERS learning community at conferences and learning labs to accelerate application of successful strategies.

Sustainable Success

The Joint Center and the BC PLACE MATTERS team will continue to engage the community and disseminate information about chronic disease disparities. The BC PLACE MATTERS team has leveraged several grants, including funds for a land-use toolkit designed to help community members educate policymakers. The team will also organize three Health Impact Assessment (HIA) training sessions for community leaders in the International District, Mountain View, and San Jose neighborhoods of Albuquerque. They will coordinate with NM Health Equity Partnership and Human Impact Partners to develop a one-page description of the benefits of an HIA for the community members. Finally, the team will continue to convene their quarterly strategic planning meeting.

YOUR INVOLVEMENT IS KEY

For more information visit:

Websites

Jointcenter.org

Bcplacematters.com

Facebook

<https://www.facebook.com/BCPlaceMatters>

Twitter

[@jointcenter](https://twitter.com/jointcenter)

[@bcplacematters](https://twitter.com/bcplacematters)

[@ourplacematters](https://twitter.com/ourplacematters)

Contact

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Lessons Learned

The Joint Center and its affiliates designed an internet strategy using tools such as Twitter, Facebook, and YouTube to engage the community and disseminate information about chronic conditions. However, the digital divide between Whites and minorities, and rural and urban communities, presented challenges with using this approach. The Baltimore City PLACE MATTERS team observed that solely posting content on their website was not the most effective way to reach their community, because some websites are configured for home computers rather than smartphones. Baltimore is largely African American, and many African Americans lack access to broadband internet at home. The Bernalillo County PLACE MATTERS team encountered a similar challenge, being based in a rural community where many lack access to broadband internet. Only 18% of rural residents have access to high speed broadband.

Though some people of color don't have access to home computers, they do have access to smart-phones. Fifty-one percent of Hispanics and 46% of Blacks use their phones to access the internet, compared with 33% of Whites, according to a July 2010 Pew poll. The figures for using social media like Facebook via phone were 36% for Latinos, 33% for Blacks, and 19% for Whites. The teams adapted to the needs of their communities and began utilizing social media platforms with mobile apps, such as Facebook and Twitter, to reach them.

In addition, the teams added a traditional community outreach and text messaging component to their approach, thereby vastly increasing their reach. For example, the Bernalillo County PLACE MATTERS team held monthly community meetings or charlas where they received feedback from the community on issues such as access to healthy foods in their neighborhoods. At the charlas, the team collected email addresses and phone numbers from the attendees and added them to their e-mail list and text messaging system. Emails were sent out to the attendees including links to the team's social media pages, and texts were sent out with reminders about upcoming events. The traditional outreach fed into social media and vice versa, thereby increasing reach. Project results demonstrated that combining social media with traditional community outreach is a stronger, more effective way to engage community members.

Resources

- » Joint Center website:
<http://jointcenter.org>
- » PLACE MATTERS website:
<http://jointcenter.org/content/place-matters>
- » PLACE MATTERS webinars:
<http://jointcenter.org/content/webinars>



NATIONAL COUNCIL OF LA RAZA

BACKGROUND INFORMATION

The National Council of La Raza (NCLR)—the largest national Hispanic civil rights and advocacy organization in the United States—works to improve opportunities for Hispanic Americans. Through its network of nearly 300 affiliated community-based organizations, NCLR reaches millions of Hispanics each year in 41 states, Puerto Rico, and the District of Columbia. To achieve its mission, NCLR conducts applied research, policy analysis, and advocacy, providing a Latino perspective in five key areas—as-sets/investments, civil rights/immigration, education, employment and economic status, and health. In addition, it provides capacity-building assistance to its Affiliates who work at the state and local level to advance opportunities for individuals and families.

Founded in 1968, NCLR is a private, nonprofit, nonpartisan, tax-exempt organization headquartered in Washington, DC, serving all Hispanic subgroups in all regions of the country. It has state and regional offices in Chicago, Los Angeles, Miami, New York, Phoenix, and San Antonio.

In 2002, NCLR established the Institute for Hispanic Health (IHH) to:

- » Reduce the incidence, burden, and impact of health problems among the Latino community and promote their well-being.
- » Partner with NCLR Affiliates, government agencies, private funders, and other Hispanic-serving organizations to design, develop, and deliver high-quality health interventions.
- » Improve access to and utilization of science-based, culturally competent and linguistically appropriate health promotion and disease prevention programs.

Project Overview

NCLR/IHH designed and developed the *Mujer Sana, Familia Fuerte* (Healthy Woman, Strong Family) project to address the need for effective cervical cancer education among Latinas. This community-based project sought to increase knowledge, change attitudes, increase intent to change behavior, and change behavior among Latinas in Washington, DC, and Chicago, IL, leading them to seek screenings for cervical cancer.

Objective: The overall goal of Mujer Sana, Familia Fuerte is to reduce health disparities by increasing the percentage of Latinas over the age of 18 who receive cervical cancer screening. Through collaboration with NCLR Affiliate community health centers and the CDC's REACH US program, NCLR/IHH developed a culturally competent and linguistically appropriate cervical cancer prevention education program led by promotores de salud (lay health educators).

Impact: IHH, through collaboration with NCLR Affiliates, offered women one-on-one and small-group education sessions led by promotores de salud and provided client reminders to motivate participants to act on the information received. The program was implemented in organizations which serve primarily Spanish-speaking immigrants, maintain active promotores programs, and have a demonstrated need in the community for increased screening.

ACCOMPLISHMENTS AND TIME COMMITMENT

Through the implementation of Mujer Sana, Familia Fuerte, over 8,000 Latinos have received in-person cervical cancer prevention education from promotores de salud, who are trusted leaders in their communities and who are often able to follow up with participants regarding their questions or other needs around obtaining cervical cancer screening.

In addition, NCLR and its Affiliates have increased the number of organizations contributing to the success of the project. In year one of the project, NCLR was working with two Affiliates who in turn collaborated with 19 organizations in their communities. By year five, this number increased to two Affiliates and four Partners in Dissemination, who are collaborating with 49 organizations in their communities.

A variety of bilingual, culturally competent and linguistically appropriate products around Latinas and cervical cancer were produced in conjunction with NCLR's local Affiliates. These products include:

1. An educational toolkit tested by the community and designed for use by promotores de salud
2. A brochure summarizing information around cervical cancer and the Latina community
3. A fact sheet with information around cervical cancer and the Latina community
4. An infographic depicting the story of how cervical cancer affects Latinas

In addition to in-person education and support, NCLR used an electronic media strategy to reach an even wider Latino audience with important cervical cancer prevention information, taking advantage of relevant observation periods such as Cervical Cancer Awareness Month, National Minority Health Month, and National Women's Health Week to bring awareness to the issue. More than 3.8 million people have been reached through these electronic media efforts, such as blogs, Facebook posts, Tweets, etc.

Success Story

MUJER SANA, FAMILIA FUERTE: INCREASING CERVICAL CANCER SCREENINGS AMONG LATINAS

by: Marcela Vargass

SUMMARY

Latinas suffer disproportionately from cervical cancer compared to other racial and ethnic groups. To address this disparity, the National Council of La Raza's (NCLR) Institute for Hispanic Health, with the help of its community-based Affiliates,* developed Mujer Sana, Familia Fuerte (Healthy Woman, Strong Family), a culturally competent and linguistically appropriate cervical cancer education intervention led by promotores de salud (community health workers). Mujer Sana, Familia Fuerte has increased knowledge, positive attitudes, self-efficacy, and intent to screen for cervical cancer among Latinas in Chicago, IL, and Washington, DC.

* NCLR's community-based Affiliate organizations deal with all aspects of serving the Latino population on a day-to-day basis. They are familiar with the practical concerns and policy issues affecting their constituencies and are actively engaged in developing and implementing innovative solutions to the problems faced by their communities.



CHALLENGE

Among racial and ethnic groups in the United States, Latinas have the second highest incidence and death rate from cervical cancer. Although Pap tests help reduce the burden of cervical cancer, Latina screening rates remain fairly low due to limited knowledge, cultural factors, and lack of access to medical care. According to NCLR Affiliates in Chicago, IL, and Washington, DC, many women who reported having gotten a Pap test had never discussed the screening or cervical cancer with a health professional. These findings, along with the disease's disproportionately high incidence and mortality rates among Latina women, underline the importance of cervical cancer prevention education in the Hispanic community.

SOLUTION

To address these barriers, NCLR's Institute for Hispanic Health, with support from the Centers for Disease Control and Prevention (CDC), developed the *Mujer Sana, Familia Fuerte* project to address the culturally specific needs of Latinas around cervical cancer prevention. The objectives of this intervention are to increase knowledge and behavioral intent and to change attitudes, and behavior regarding cervical cancer screening among Spanish-speaking Latinas through *charlas* (health education sessions) led by *promotoras de salud*.

RESULTS

Overall, participants have reported significant increases in cervical cancer knowledge, positive attitudes, and self-efficacy to obtain Pap tests. From pre- to post-*charla*, there was a statistically significant increase in intention to have a Pap test in the future. At three month follow-up, one third of women had received a Pap test since participating in the *charla*. The most common reason given for why some women had not screened was that it was not yet time for their doctor's appointment. Demographic analysis revealed that age, education level, and marital status may be important considerations when promoting cervical cancer prevention efforts to Latinas. In summary, results from *Mujer Sana, Familia Fuerte* have demonstrated that the program can positively impact knowledge, positive attitudes, self-efficacy, and intention to screen for cervical cancer among Latinas.

FUTURE DIRECTIONS

One of the major project findings from *Mujer Sana, Familia Fuerte* indicates a need for patient navigation to encourage cervical cancer screening among Latinas. NCLR hopes to incorporate a patient navigation component in future iterations of this project.

Ensuring the availability of culturally competent and linguistically appropriate education is imperative to reduce the health disparities around cervical cancer. NCLR is working to build capacity within its Affiliate partner organizations so that they may continue this important task in their respective communities. In addition, NCLR is actively seeking opportunities to share challenges faced and lessons learned during the implementation of *Mujer Sana, Familia Fuerte* to aid others engaged in this critical work.

YOUR INVOLVEMENT IS KEY

Increasing Pap test screening among Latinas will help catch abnormal cells or early stage cervical cancer when treatment is still relatively simple.

You can help by supporting culturally competent and linguistically appropriate health education as well as the implementation of patient navigation systems to help women access Pap tests.

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“So many Latinas are suffering and dying from cervical cancer who simply don’t have to. We’re lucky to be able to train people who live in these communities to teach others about cervical cancer screenings and finding appropriate care.”

— Manuela McDonough, Associate Director,
NCLR Institute for Hispanic Health

Lessons Learned

- » Participating organizations faced several challenges in providing cervical cancer prevention information to Latinas in their community, including:
 - Lack of childcare during the health education sessions
 - Lack of financial support for promotores
 - Lengthy project evaluation process
- » While providing information is important, more work around access issues is needed. Barriers/access issues reported for participants after receiving the charla (health education session):
 - Long wait times for a free or low-cost Pap test at local community organizations
 - Participants' need for extensive patient navigation services in order to successfully obtain screenings
- » According to the project evaluation, culturally competent and linguistically appropriate cervical cancer educational materials demonstrated a significant increase in:
 - Cervical cancer knowledge
 - Positive attitudes towards Pap tests
 - Self-efficacy around getting Pap tests
 - Intentions to obtain Pap tests
- » To reduce the transmission of HPV and thus the incidence rate of cervical cancer, and to address barriers to screening and services, both males and females must receive information and services.
- » Promotores de salud, or community health workers, can reach and educate underserved and linguistically isolated populations in a culturally appropriate manner, facilitate access to screening services, and provide social and emotional support.

Resources

- » Centers for Disease Control and Prevention. "Cervical Cancer Rates by Race and Ethnicity." August 2013. <http://www.cdc.gov/cancer/cervical/statistics/race.htm>
- » Centers for Disease Control and Prevention. "Prevent Cervical Cancer" Infographic. August 2013. http://www.cdc.gov/cancer/cervical/basic_info/infographic.htm
- » National Council of La Raza. Cervical and the Latina Community. January 2013. http://www.nclr.org/images/uploads/publications/Cervical_Cancer_Fact_Sheet_English.pdf
- » National Council of La Raza. "Latinas: When was your last Pap test?" Infographic. January 2014. http://www.nclr.org/index.php/publications/latinass_when_was_your_last_pap_test
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SOCIETY FOR PUBLIC HEALTH EDUCATION



BACKGROUND INFORMATION

SOPHE is a 501(c)(3) professional organization founded in 1950, whose mission is to provide leadership to the profession of health education and contribute to the health of all people and the elimination of health disparities through advances in health education theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health.

Collectively, SOPHE's 4,000 international, national, and chapter members include professionals who work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of government. Spanning more than 30 states and all 10 HHS Regions, SOPHE's 20 chapters provide continuing education, networking, advocacy, and technical assistance at the state and local levels. SOPHE provides health promotion, training, and capacity-building expertise.

SOPHE's Health Equity Project, "Sustainable Solutions for Health Equity," aims to engage the REACH Centers of Excellence in the Elimination of Disparities (CEEDs) and Action Communities by empowering its chapters, community-based organizations, and community members to reduce diabetes and related risk factors among African American/Black and American Indian/Alaska Native populations.



Georgia SOPHE targeted an African American/Black population in the rural area of Jenkins County, GA, partnering with chapter members and faculty at Georgia Southern University to work with the community-based Jenkins County Diabetes Coalition in Millen. Northern California SOPHE Chapters targeted an American Indian/Alaska Native population in the urban area of Oakland and partnered with Seva Foundation

to work with the only community-based Native American center in the San Francisco Bay area, Intertribal Friendship House.

National SOPHE's goal is to build the capacity of SOPHE Chapters to establish collaborative partnerships focused on the dissemination of evidenced-based tools and strategies to eliminate health disparities among racial and ethnic populations. National SOPHE continues to work with the House of Delegates leadership to incorporate activities to address health disparities among local and regional SOPHE Chapters areas.

ACCOMPLISHMENTS AND TIME COMMITMENT

SOPHE is engaging its Chapters, REACH CEEDS, national partners, and community-based organizations to support a national framework to eliminate health disparities and promote health equity. SOPHE is building on its work in health equity and with REACH CEEDs by utilizing the latest theory, evidence, and skills in social marketing; leadership development; program planning; evaluation; coalition-building; and policy, systems, and environmental change, to enhance the capacity and development of its Chapters and local minority communities in preventing, managing, and treating chronic disease among African American and American Indian/Alaska Native populations.

SOPHE's Board of Trustees submitted comments for consideration in the revisions to the 2007 National Standards for Diabetes Self-Management Education (DSME). SOPHE cross walked the Certified Health Education Specialists (CHES) and Master Certified Health Education Specialists (MCHES) competencies and sub-competencies with the 2007 DSME Standards. The comments outlined SOPHE's proposal that CHES/MCHES be recognized and designated as a professional partner within multidisciplinary teams assisting with the delivery of DSME and be included in the revised National Standards. SOPHE successfully petitioned for the MCHES designation to be eligible to take the Certified Diabetes Educator exam. SOPHE also has initiated conversations with the American Association of Diabetes Educators and other diabetes-related organizations to educate them about CHES/MCHES and to pursue recognition of their potential contributions to diabetes prevention and control. SOPHE's collaborative efforts focused on the institutional factors influencing the community level and on social networks to affect population health, which are key concepts of an ecological perspective.

National SOPHE partnered with the CDC's Division of Diabetes Translation to distribute a total of 133 English and 47 Spanish Road to Health Toolkits to all SOPHE Chapters. The toolkit is a resource that SOPHE Chapters can share with their members, communities and partners to address the diabetes disparity within their state/region. The Road to Health toolkit is provided to SOPHE Chapters to encourage collaborative partnerships with community-based organizations and partners committed to implementing evidence-based outreach education among Hispanic/Latino or African American/African Ancestry communities, but the toolkit can appeal to anyone. The Road to Health Toolkit provides real-life examples, hands-on activities, and interactive ideas which focus on healthy food choices and increasing physical activity.

Success Story

SOPHE SUSTAINABLE SOLUTIONS FOR HEALTH EQUITY NATIONAL POLICY CHANGE

By: Nicolette Warren



SUMMARY

Georgia SOPHE targeted an African American/Black population in the rural area of Jenkins County, GA, partnering with chapter members and faculty at Georgia Southern University to work with the community-based Jenkins County Diabetes Coalition in Millen. Northern California SOPHE Chapters targeted an American Indian/Alaska Native population in the urban area of Oakland and partnered with Seva Foundation to work with the only community-based Native American center in the San Francisco Bay area, Intertribal Friendship House.

CHALLENGE

Diabetes is the seventh leading cause of death in the United States. According to the CDC, in 2012, 21 million people were diagnosed with diabetes, while 8 million people were undiagnosed and 79 million were diagnosed with prediabetes, a state which carries a high risk for developing type 2 diabetes. By 2050, an estimated 48 million U.S. residents are expected to have diagnosed diabetes. Diabetes is a leading cause of kidney failure, new blindness in adults, and leg and foot amputations unrelated to injury; it is also a major cause of heart disease and stroke.

SOLUTION

National SOPHE partnered with the CDC, Division of Diabetes Translation to distribute Road to Health Toolkits, a resource that SOPHE Chapters can share with their members, communities and partners to address the diabetes disparity within their state/region. SOPHE is working to incorporate activities that address health disparities among local and regional SOPHE Chapters areas. The

ACA covers preventative services, i.e. diabetes screenings, with no cost to the patient, and diabetes self-management education/training is interactive, collaborative, cost-effective and an ongoing process that improves health outcomes as patients maintain better control of their A1c. Diabetes educators provide this training and enable physicians to provide comprehensive high quality care for their patients with diabetes and those at high risk. Certified Health Education Specialists (CHES) and Master Certified Health Education Specialists (MCHES) also provide and manage health education programs that help individuals, families, and their communities maximize and maintain healthy lifestyles.

RESULTS

National SOPHE partnered with the CDC, Division of Diabetes Translation to distribute a total of 133 English and 47 Spanish Road to Health Toolkits to all SOPHE Chapters. The Road to Health toolkit is provided to SOPHE Chapters to encourage collaborative partnerships with community-based organizations and partners committed to implementing evidence-based outreach education among Hispanic/Latino or African American/African Ancestry communities: <http://www.cdc.gov/diabetes/ndep/index.htm>. In addition, SOPHE's Board of Trustees submitted comments for CHES and MCHES to be recognized and designated as professional partners within multidisciplinary teams assisting with the delivery of Diabetes Self-Management Education (DSME), and successfully petitioned for the MCHES designation to be eligible to take the Certified Diabetes Educator exam. SOPHE's collaborative efforts focused on the institutional factors influencing the community level and on social networks to affect population health, which are key concepts of an ecological perspective.

SUSTAINABLE SUCCESS

The new partnership with CDC, Division of Diabetes Translation helped to sustain the efforts of the SOPHE Health Equity Project. Georgia and Northern SOPHE Chapters can offer technical assistance to other SOPHE Chapters based on the lessons learned from implementing evidence-based programs with community partners. Also, the new partnership expands the number of SOPHE Chapters partnering with organizations to address diabetes disparities. SOPHE has initiated conversations with the American Association of Diabetes Educators (AADE), National Certification Board of Diabetes Educators (NCBDE), American Diabetes Association (ADA), and the National Diabetes Education Program (NDEP) to educate them about CHES/MCHES and to pursue recognition of their potential contributions to diabetes prevention and control. This is another example of National SOPHE working with the House of Delegates leadership to incorporate activities to address health disparities among local and regional SOPHE Chapters areas.

YOUR INVOLVEMENT IS KEY

- » Become a member of National SOPHE and join a local SOPHE Chapter
- » Seek the CHES or MCHES credential for career advancement
- » Become a part of the ADA, AADE, NDEP, or the NCBDE Mentoring Program.
- » Implement the Road to Health Toolkit (contact the local SOPHE Chapter to secure a free copy, http://sophe.sophe.org/chapters_sophe_list.asp) and the National Diabetes Prevention Program
- » Educate stakeholders at the national, state, and local levels about the importance of health education and health promotion efforts

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Lessons Learned

Critical personnel issues for successful project implementation:

- » Selection of key partners
- » Managing key project staff turnover
- » Establishing standard operation procedures of all chapter activities and especially the policy and procedure to handle key personnel compliance
- » Leadership development and training of volunteers
- » Staff training
- » Communication style

Essential elements for sustaining community-based collaborative partnerships:

- » Timeframe to establish: at least 6–9 months
- » Trust and respect
- » Equitable funding to key community-based partners
- » Representation of community members with diabetes and other related chronic disease (for planning self-management programs)
- » Development of community-based collaborative partnership agreements
- » Initial needs assessments and trainings (for building effective action plans)
- » Cultural competency

Key issues in project evaluation:

- » Establishing clear project expectations
- » Identification of project reporting tools (for managing technical assistance)
- » Development of competency-based technical assistance requires a team approach with experts and community involvement
- » Technical assistance must be strategic and useful
- » Managing funder expectations with community partners' expectations
- » Evaluating dissemination efforts (for assessing project reach)

Key elements of chapter capacity-building:

- » Strong membership recruitment and retention plans
- » Accountability and commitment for chapter activities (e.g. project management and implementation, evaluation, continuing education, partnerships, resource development, marketing, communication and dissemination)
- » Creating a balance between building chapter capacity, improving individual and community health, and promoting the field of health education
- » Chapter access to technology (e.g. website, internet, computer, office space, electronic communication)
- » Chapter must have foundation to operate as an independent nonprofit organization
- » Providing unique opportunities to reconnect with colleagues helps to rejuvenate commitment
- » Offer in-depth webinar content
- » Provide chapters with sustainable funding to support capacity-building, development, and project implementation

Resources

- » Media Guide for SOPHE Chapters (Focus Area: Dissemination)
http://www.sophe.org/Sophe/PDF/Media_Guide_for_SOPHE_Chapters.pdf
- » Diabetes Toolkit (Focus Area: Partnership and Diabetes Disparity)
http://www.sophe.org/Sophe/PDF/Diabetes_toolkitrevised.pdf
- » Health Equity Guide for Stakeholders (Focus Area: Partnership & Dissemination)
http://www.sophe.org/Chapters_Guide_to_Promoting_Health_Equity_Final_4.pdf
- » SOPHE Webinars (Focus Area: Dissemination and Technical Assistance) Archive webinars are located in the Centers for Online resources and Education (CORE)
<http://www.sophe.org/education.cfm>
- » SOPHE Midyear and Annual Meeting (Focus Area: Dissemination) Recorded meeting sessions are located in the SOPHE Knowledge Center
www.sophe.org/knowledgectr.cfm
- » Chapter Succession Planning (Focus Area: Technical Assistance) Purpose: Chapters must be able to recruit and retain chapter leadership to effectively operate and plan activities to eliminate health disparities.
http://www.sophe.org/chapter_succession_planning.pdf
- » Recognizing Health Education Specialists Roles in Diabetes Prevention and Management: A Toolkit for Diabetes Self-Management Education (Focus Area: Technical Assistance and Dissemination)
http://www.sophe.org/DiabetesSelf-ManagementHealthEducatorToolkit_Final.pdf
- » SOPHE HEP Infographics (Focus Area: Dissemination)
http://www.sophe.org/SOPHE_Health_Equity_Project_Infographic_82714.jpg

- » SOPHE Health Equity Project Fact Sheets (Focus Area: Dissemination)
http://www.sophe.org/Sophe/PDF/SOPHE_Health-Equity-Project-factsheet-v4.pdf
- » SOPHE Health Equity Project Video Links:
 - REACH: Improving Lives, Inspiring Hope
<http://www.youtube.com/watch?v=ehKXuYqjHbA>
 - CDC REACH MNO video
<https://www.youtube.com/watch?v=iima6D943xQ>
 - SOPHE REACH MNO Video
http://www.youtube.com/watch?v=nq8hD3Q_aWE
 - Northern CA SOPHE Video
<http://www.youtube.com/watch?v=NAFLKwrAvcc>





Chapter Six

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²⁰ Ibid.

²¹ Ibid.

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