

# OCMH Grantee Abstracts

## Demonstration Grantees

**Grantee Agency:** Hospital Council of Northwest Ohio

**Project Title:** Care Connections: Reducing the Burden of Chronic Disease

Lucas County is the largest county in Northwest Ohio and Toledo is its largest city, making up 65% of the county's population. While the State of Ohio has combined African American and Hispanic population of 15%, Toledo's combined population is 34.6%. The Lucas County Community Health Needs Assessment findings confirm that chronic diseases, especially heart disease, cancer, stroke, diabetes, obesity, and related risk factors (tobacco use, physical inactivity and poor diet) are the leading causes of death and disability in Lucas County. Specifically, diabetes is the third leading cause of death for African American females, and the fourth leading cause of death for African American males. African American rates for heart attack, high blood pressure, diabetes, overweight/obesity, and current smokers in Lucas County are much higher than the county, state, and nation, with the prevalence of diabetes at 15% among all adults, increasing to 21% for African Americans.

"Care Connections: Reducing the Burden of Chronic Disease" will collaborate with "Healthy Lucas County-Good Health for All" (HLC-GHA), a recent awardee of the Centers for Disease Control and Prevention *Partnerships in Community Health* (PICH) grant, to decrease disparities in chronic disease, with an emphasis on diabetes, in six targeted zip codes in Toledo. Each year of the grant, 100 men and/or women with two or more risk factors for developing diabetes or another chronic condition, or have been diagnosed with diabetes will be enrolled in the program. Utilizing the Pathways Outcome Production Model, this project will contract with four community agencies and/or health systems to hire Community Health Workers (CHW) that will provide care coordination services to enrolled clients. The goal of the CHW is to remove barriers to care (i.e. housing, food, transportation, etc.) so that the client is able to access best practices (i.e. medical care). This care coordination will further the goals of Ohio's Plan to Prevent and

Reduce Chronic Disease to: 1) Decrease the prevalence of diabetes among adults by 5 percent; 2) Decrease the percent of diabetic adults with poor hemoglobin A1C control (>9.0 percent) by 5 percent; 3) Increase the prevalence of adults consuming 5+ servings of fruits/vegetables per day by 5 percent; 4) Increase the prevalence of adults meeting physical activity guidelines for aerobic activity and muscle strengthening by 5 percent.

Since 2010, the Northwest Ohio Pathways HUB, through the Lucas County Initiative to Improve Birth Outcomes, has contracted with Medicaid Managed Care plans that provide payments for measurable outcomes met with our high risk pregnant population. "Care Connections" will demonstrate to our community and Medicaid Managed Care the success of utilizing the Pathways Model to reduce the burden of chronic disease. By the end of this two year demonstration project, HUB staff will present data collected through this project to Medicaid Managed Care, with the goal of securing contracts to sustain the services beyond this demonstration grant.

**Grantee Agency:** Health Care Access Now

**Project Title:** D4Prevention

Minorities and people in poverty experience worse health care quality and access, resulting in disproportionately higher rates of chronic disease, disability, and mortality. Data show an increase in diabetes between 1999 and 2013 from 9% to 13% in the Greater Cincinnati region, with African Americans (14%) and persons living at or below 100% of the Federal Poverty Level (FPL) (17%) reporting higher rates of diabetes. Disparities related to weight, nutrition, and physical activity, are also prevalent. 76% of African Americans are overweight or obese, compared to 64% of whites. Adults living below 200% FPL are more obese (38%) than adults living above 200% FPL (31%). A continuum of multi-level, preventive and health promotion services are needed to prevent and control diabetes, and avoid its personal and public health impact. Given the large role behavior plays in disease development, lifestyle modifications are the first line of therapy for diabetes prevention. Addressing barriers and linking to social and community support are also critical to increase the adoption of healthy lifestyles to prevent disease.

*D4Prevention (D4P)* is the proposed multi-level, culturally relevant program that

integrates prevention and lifestyle modification services into two community-based primary care practices in Cincinnati, OH and supports lifestyle changes through community support linkages. *D4P* combines four evidence-based, culturally relevant prevention practices – screening, Pathways Model, Health Empowerment Lifestyle Program (HELP), and Diabetes Prevention Program (DPP) to improve health status and outcomes for type 2 diabetes, among economically disadvantaged African Americans. Community Health Workers will implement *D4P* to provide continuity across prevention components, serving as bridges between their ethnic, cultural, and geographic communities and health care providers, and engaging patients to prevent diabetes through education, lifestyle change, self-management, and social support. *D4P* goals are to: 1) increase access to diabetes prevention information and activities; 2) reduce diabetes risk factors, and; 3) prevent diabetes diagnoses. *D4P* will serve 200 patients over the two-year grant period – 200 will receive care coordination services via the Pathways Model, and based on risk stratification, 100 will participate in HELP and 100 in DPP. *D4P*'s evaluation will include process and outcome components to monitor implementation, improve effectiveness, document outcomes, and promote replicability. The process evaluation will monitor implementation and fidelity, document service participation, and assess program experiences. A pre-/post-test design will monitor change between baseline and quarterly performance measures, including all required outcome indicators for diabetes education/behavior change: demographics, height and weight, BMI, hA1c, diabetes knowledge, nutrition, physical activity, and tobacco use. *D4P* will integrate diabetes prevention into healthcare settings, increasing access to these critical prevention services for persons at-risk for developing diabetes. Participation in *D4P* will address preventable risk factors that lead to diabetes and will specifically increase knowledge about the disease, improve nutrition, increase physical activity, and reduce BMI and tobacco use. These behavioral changes will improve patient health and reduce diabetes diagnoses among a population disproportionately impacted by this disease.

**Grantee Agency:** Murtis Taylor Human Services System

**Project Title:** Diabetes Intervention Program Program (DIP)

Murtis Taylor Human Services System (MTHSS) will pilot a Type 2 Diabetes Demonstration Program based on the Evidence-Based, National Diabetes Prevention Program that targets adults, age 55 years and older at risk for Type 2 Diabetes. The primary focus will be the prevention of Type 2 Diabetes. A secondary population target will be adults already diagnosed with pre-Type 2 Diabetes. The target population will be 100 low- and fixed-income adults ages 55 years and older who live in the Mt. Pleasant neighborhood in Cleveland, Ohio. The majority (90%) of participants are expected to be low and limited income African-Americans.

Primary prevention activities will include administration of the U.S. Centers for Disease Control (CDC)-approved health risk assessment to identify lifestyle factors and family heritage that can make an individual at higher risk for diabetes, nutrition awareness and education and exercise and fitness sessions which will reduce or eliminate known risk factors and support lifestyle improvement. There will be weekly interactive education and awareness sessions, presenters, opportunities for physical activity, diabetes risk assessment, referral to medical assessments if needed and referral to social and supportive services and support. Participants will also be linked to web-based tools and resources and community resources such as fresh food markets and the City of Cleveland Neighborhood Recreation Centers.

The modality for implementation is case management in the form of lifestyle coaching. Lifestyle Coaches will assist and empower participants to learn and practice strategies for incorporating physical activity into daily life and making healthy/ier food choices. Lifestyle Coaches will work one-on-one and in group sessions with participants to identify emotions and situations that can sabotage success and share strategies for dealing with challenging situations. Strategies to be used to achieve these goals will include a focus on self-monitoring of diet and physical activity, building of self-efficacy and social support for maintaining lifestyle changes, and problem-solving strategies for overcoming common challenges to sustaining weight loss.

Program Goals are, 1) Improve nutritional choices (change/improve eating behaviors), 2) Increase physical activity levels and 3) Enhance long-term weight management among all participants. Objectives are, 1) 50% (50) of participants will increase daily servings of fruits and vegetables by 60%, 2) 25% (25) of participants will increase daily activity levels to a minimum 150 minutes of brisk physical activity each week, 3) 25% (25) of participants will reduce their body mass index percentile by 5-7%, 4) 60% (60) of participants will increase daily water intake by 50% and 5) 25% (25) of participants will achieve weight loss of 5% - 10%.

**Grantee Agency:** The Research Institute at Nationwide Children's Hospital

**Project Title:** Step by Step: Diabetes Prevention Program for People Living with HIV.

The Minority Health Diabetes Education Project is an intensive, multidisciplinary program targeted at HIV-infected patients at high risk for developing DM2. The demonstration project is designed to introduce lifestyle modifications and reduce the risk of DM2 incidence. The program features:

- An educational component consisting of monthly expert-led interactive presentations, 10 during the year, designed to increase knowledge and awareness about nutrition, diabetes, heart disease, obesity, exercise; hands-on healthy cooking demonstrations also will be included.
- A physical activity component with monthly group exercise led by a fitness instructor, a total of 10 classes during the year. Program participants will be provided with an activity tracker to monitor their daily physical activity level.
- One-on-one meetings between a dietitian and each program participant at least three times during the year to determine personal dietary and physical activity goals, to design an individualized diet and exercise plan, and to periodically review progress and milestones achieved. Incentive rewards will be provided to participants upon reaching specific milestones.

**Grantee Agency:** Wright State University

**Project Title:** Research and Evaluation Enhancement Program (REEP)

The Research and Evaluation Enhancement Program provides technical assistance and evaluation support to the Ohio Commission on Minority Health's Demonstration Projects and Local Offices of Minority Health Capacity Building Projects. REEP evaluators are assigned to projects based on location and provide technical assistance with data collection, program evaluation recommendations, and annual and biannual grant reports.