National Public Health Leadership Development Network
Balderson Leadership Project Summaries

Kansas Public Health Leadership Institute

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Addressing Health Disparities in Highly Specialized Minority Populations: Case Study of Mexican Mennonite Farmworkers

The Kansas Statewide Farmworker Health Program (KSFHP) has developed a unique set of culturally competent health interventions in response to the pressing public health needs of the state's underserved farmworker population. Key among these are its health education and translation efforts on behalf of the fast-growing Low-German-speaking Mexican Mennonite farmworker population. Linguistic, religious, and cultural values have created unique and complex health disparities and barriers to care that can be broken down only through innovative approaches. KSFHP first conducted a health needs assessment survey of the farmworker population in 2003, which indicated prenatal care practices as a significant health disparity, especially among the Low German-speaking Mexican Mennonite population. In response, KSFHP implemented a new standard of health behavior data collection that includes primary language data as a method of delineating population subgroups, making Kansas one of the first two states in the country to collect this information. KSFHP also developed culturally competent Low German-language recordings on health topics such as prenatal care in accordance with the information delivery needs of the Low-German-speaking Mexican Mennonite farmworker population. Currently, a pilot program is in progress that offers additional outreach, health education, and interpretation, among other services. The work of the KSFHP has significant implications for further research into health disparities, specialized minority populations, and culturally competent data collection methods.

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Improving Behavioral Health Services Through Enhanced Communications

Improving the behavioral health of a specified population must begin with assurance that access to care in uncomplicated for consumers. At the very least, a comprehensive communication system should exist between the service providers and public points of contact within the community. Dorchester County was not effectively communicating its services and contact information to the community it serves. Even some mental health "experts" had difficulties understanding how and where clients could obtain particular services.

The Dorchester County team resolved this problem by developing and distributing the **Behavioral Health Resource Guide**, which will improve access to health services for the community. The resource guide does state that the information included was collected by questionnaires to providers, and a listing in the Guide does not indicate a recommendation of a particular provider. The guide is provided as an information resource – a place to begin.

The team developed a SurveyMonkey to collect information and learned that the most difficult task in this project was receiving completed questionnaires. The team recommended that the Guide be updated annually so that the resource is current. The Dorchester County Health Officer accepted responsibility to assure continuation of the Guide.

This team was assisted by a Calvert County scholar who volunteered a copy of a guide produced in Calvert County. These materials were adapted for the Dorchester County Resource Guide.

The Guide begins by listing the County's 24-Hour Emergency Hotlines and an additional page for other contact information deemed important to the recipient of the Guide. Following that, the Guide defines mental health, gives problem warning signs and factors that affect mental health, guidance on choosing the right mental health therapist, how to handle emergency situations, and a description of the varied treatment methods.

A detailed provider listing follows which includes the provider name, address, telephone and fax numbers, hours of operation, additional locations, services provided, population served, and payment sources.

This Resource Guide was duplicated and available at the Dorchester County Health Department, Health Care Providers, libraries, local public health agencies and organizations.

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Childhood Obesity: Developing a Multidisciplinary Program in a Community Health Center

I. Project Overview

On July 16, 2003 the Surgeon General testified before the United States House of Representatives, Subcommittee on Education Reform on the "Obesity Crisis in America." In his testimony the Surgeon General announced that obesity is the fastest growing preventable cause of death in America. Nearly two out of every three Americans are overweight or obese and one out of every eight deaths in America is caused by an illness directly related to overweight/obesity.

National data shows an increasing trend in obesity and overweight among young people. Results from the 1999-2000 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, show that an estimated 15 percent of children and adolescents ages 6-19 years are overweight. This represents an increase from previous years' estimates, suggesting the likelihood of another generation of overweight adults who may be at risk for related health conditions. The health consequences of childhood obesity are numerous including: the medical impact of Asthma, Type 2 Diabetes Mellitus, poor mental health, the risk of obesity in Adulthood, and the increased economic costs in the healthcare system due to increased hospitalizations for treatment of obesity associated conditions.

The situation among minority communities is more severe than the general population. Non-Hispanic black and Mexican American adolescents, ages twelve to nineteen were more likely to be overweight (24%) than non-Hispanic white

adolescents (13%). Other statistics show that Mexican-American children, ages six to eleven were more likely to be overweight (24%) than non-Hispanic black children (20%) and non-Hispanic white children (12%). The local impact was captured in a survey of five Chicago inner-city neighborhoods (West and South sides of the city) with rates of childhood obesity well above 45%.

The purpose of this technical assistance project is to propose elements of a multidisciplinary treatment and prevention program for risk factor identification, reduction and control for children and adolescents affected by obesity/overweight at the Mile Square Health Center ("MSHC"). MSHC is a Federally Qualified Community Health Center affiliated with the University of Illinois based on the Near West side of Chicago. It is located in a large and diverse community with significantly elevated rates of childhood obesity. The Code Red Team has been asked to provide background information and research on best practices to facilitate MSHC's development of an obesity treatment program.

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Implementing the Health Disparities Collaborative – Cardiovascular Disease: UIC – Mile Square Health Center

"We emphasized, almost at every meeting, that the process is Collaboration. Not only a collaboration of various staff members, but a collaboration with our patients (in introducing the concepts of self-management of care), with our clinical partners (the University of Illinois at Chicago Hospital), and our community partners (i.e. the American Heart Association)."

Overview and Background

In 1998, the Bureau of Primary Health Care (of the Department of Health and Human Services) set a goal to eliminate health disparities for 12 million underserved Americans, and guaranteeing them 100% access to quality health care by 2010. In order to achieve the goal, the Bureau is sponsoring a series of Health Disparities Collaboratives - which are designed to bring together health centers to develop rapid improvements in care. Using a "Care Model" that specifies the essential elements of excellent care, health centers have been able to demonstrate success in improving diabetes care, asthma, depression, cancer, cardiovascular disease, and HIV. The UIC - Mile Square Health Center (MSHC) started participating in the Collaboratives in July of 2003. The Core Team of the Collaborative under the direction of the health center's Senior Leadership determined to establish a system for improved care for patients in the Cardiovascular track. The principal goals of this collaborative are to improve the quality of care and reduce health care disparities among patients with CVD, specifically hypertension, dyslipidemia, and CAD, within the populations served by the health center.

Cardiovascular diseases (CVD), including hypertension, coronary artery disease (CAD), heart failure, and stroke, are the leading cause of death among both men and women of all racial and ethnic groups in the United States. It is estimated that 61.8 million Americans have CVD, including 29.7 million men and 32.1 million women. The prevalence of hypertension is about 50 million, and about 12.6 million Americans have CAD. In addition, gaps in care are greatest in underserved and

vulnerable populations, care often provided by Community Health Centers. The Core Team of MSHC proposed that by restructuring the practice of chronic disease and using the Care Model's six components, we would accomplish this, and also incorporate the entire health center in the care of our patients. In addition to the measures listed below, we have established an implicit goal of improved follow-up for all our patients, integrating participation of patients and their families to ensure follow-up and decreasing no show rates.

1) Documentation of 2 BPs in the last year >90%
2) Percentage of hypertensive patients with BP < 140/90 >50%
3) Documentation of Fasting Lipid profile in the past 5 years >80%
4) Percentage of patients with CAD/DM with fasting LDL<100 mg/dl >60%
5) Percentage of patients with documented self-mgmt goals in last 12 mos. >70%
6) Percentage of patients with CAD currently taking ASA or other antithrombotic agent >90%

Additional Measure:

1) Percentage of patients with DM and CAD with two HbA1cs3 mos. apart >90%

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HEALTH: *H*ealth *E*ating, *A L*ife-*T*ime *H*abit Training Manual

Background: Obesity rates in the United States are at epidemic proportions affecting more than sixty percent of its citizens. Trust for American's Health (TFAH) reported in October 2004 that Alabama as the heaviest state with 28.4 percent of adults being obese. These data were alarming given that many federal anti-obesity programs have been developed aimed to drop the obesity rate to fifteen percent by the year 2010. Just as the state and national trend toward obesity is increasing for adults, there is also an increase in obesity among Alabama's youth. In 2003, the Youth Risk Behavior Survey (YRBS) showed that fourteen percent of Alabama youngsters were at risk for being overweight and fourteen percent were already overweight. These estimates were based on 'overweight' being described as body mass index at or above the 95th percentile for age. The TFAH report ranks Alabama as having the seventh highest overweight level for high school students. Clinical findings documents that with such an increase in obesity, there is increase in diabetes, cardiovascular disease, joint problems, breathing difficulties, and cancers. The TFAH report also ranks Alabama ninth in spending for obesity-related medical costs. Currently, there are no signs that the trend towards obesity is dropping and therefore, intervention is necessary to deal with this life-threatening epidemic. Counseling from a child's pediatrician, who is equipped with the necessary tools, is a one way to begin the journey to a healthy weight. However, members of a task force to review the state of health of Alabama's youth determined that the pediatricians in the State did not have an appropriate tool to guide them to lead their young patients to lower their BMI.

Objective: To create a user friendly healthy lifestyle training module for physicians and lay people, to help reduce the incidence of obesity among children in the State of Alabama.

Method: Initially, the Alabama Leadership Class of 2005 reviewed ten years of height and weight data for Health Department clients ranging from ages two to eighteen years old in an effort to reemphasize the need for a healthy lifestyle training tool. Each child was evaluated for being overweight or at risk, based on their body mass index (BMI). The bulk of the project involved team members collaborating with the Alabama Task Force to pull together a health care provider training manual consisting of a readiness-to-change assessment, a treatment plan, sample meal plans, activity plans, and a patient contract. One of the team members served as a liaison between the team and the Task Force so that the manual incorporated items that the physicians would be able to use during a regular office visit. The Department of Public Health's (DPH) Communication and Design Bureau will manufacture the final product which will be distributed to the Task Force and the DPH for dissemination to the health care providers for youths.

Results & Expected Outcome: Preliminary review of the BMI data indicates that Alabama, indeed, has a significant overweight crisis among its young population. The data indicates that twenty-five percent of children in kindergarten are over weight or obese and that by third grade the obesity level increases rapidly. Once the manual is printed and disseminated, it is expected to be used by youth health care providers to counsel such clients The readiness-to-change assessment tool will play an important part in helping to determine if both the parent and client are geared up to make the necessary adjustments in their lifestyles for better health. Those patients that appear to be ready will be prescribed a treatment plan along with menu guides and suggestive age-appropriate physical activities to encourage weight loss. Another key element in the manual will be the contract whereby the parent and patient signatures denote commitment to the follow treatment plan developed by the physician. The task force has reviewed most of the materials and is encouraged that the manual will play a significant role in helping to reduce the growing trend towards obesity among Alabama's youths.

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Communication Needs Assessment and Message Mapping Workshop for Public Health Preparedness in Kansas

Current interest in terrorism preparedness efforts lends particular interest to any work dealing with assessments and practical training methods. By seeking information about the preparedness needs of certain populations, it is expected that preparedness efforts can be developed to become more effective in the event of a future attack. This project, the development and implementation of a bioterrorism information needs workshop, brings together information gathering and program development on terrorism-related topics.

The Kansas Bioterrorism Program, which facilitated this workshop, aims to communicate effectively with the state's largely rural population in the event of a public health emergency. To meet this objective, the program oversaw a statewide communications needs assessment and a message mapping workshop, both the first of their kind ever performed on behalf of the Kansas Department of Health and Environment (KDHE).

The communication needs assessment was performed in October 2003 through telephonic focus group research. The purpose of this effort was to gather information about the communication needs of public health professionals in order to prepare them for response to a variety of public health emergency scenarios. KDHE then used this information to create a workshop with the objective of instructing partner agencies in techniques for developing effective risk communication methods. The workshop's purpose was twofold: to establish best practices for agencies to develop messages (known as "message mapping"), thereby facilitating a collaborative approach to preparedness and response; and to encourage the development of risk messages prior to emergencies so that these tasks would not have to be performed in the midst of an actual crisis.

The barriers to success of the needs assessment and workshop included the following: a relative shortage of qualified participants to serve on focus groups, educating potential participants (most of whom were not communications specialists) as to the value of the projects, evaluating the cultural competency of

participants for their ability to determine the communications needs of special populations within their jurisdictions, and logistical considerations.

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Roadmap to a Healthier Life

BACKGROUND : There exists a mandate for the local health departments to implement Federal and State legislation to promote healthy life activities. These directives are outlined in each of these documents: November 2000 Coalition for a Healthy Arkansas Today (CHART) Plan, Healthy Arkansas 2010 and the Hometown Health and Arkansas Act 1220.

OBJECTIVE: The purpose for the Roadmap to a Healthier Life Team Project is to recognize some local initiatives in working to match the mandates with local resources to meet the current tasking to promote healthy life choices. It is our desire to recognize some of the more effective programs and develop standardized educational materials to aid the local effort.

METHOD: The team members have developed a county-based spreadsheet to log exercise activities. This tool tracks activity by months, then weights this activity to allow equal representation between the smaller and larger counties, and lastly provides a graph to allow easy tracking of progress. Fellow SCPHLI Class Members were asked to participate in a Pedometer Walking Program to achieve a goal of 10000 steps per day. The participants were provided a tracking sheet and a pedometer to track their progress. A brochure was developed to inform and promote healthy eating encouraging people to consume five fruits and vegetables a day and have age appropriate health screenings.

RESULTS: The county fitness-tracking tool is being utilized in a modified form, in a combined Arkansas Department of Health and Arkansas Department of Human Services Healthy Employee Lifestyle Program (HELP). Our healthy eating and age

appropriate health-screening brochure is available for local hometown health administrator's use. The results for the SCPHLI Pedometer Walking Program will be included in the presentation of the team project and final report September 15, 2005.

CONCLUSION: Our public health efforts to promote healthy lifestyle choices are both timely and necessary to meeting current and future needs of the population served. With escalation of health care costs, limited resources and poor health's negative affect on individual quality of life more public health resources will be necessary to continue and promote these efforts. Negative lifestyle choices such as obesity, physical inactivity and tobacco use have created demands on public health for education to address this pending healthcare crisis.