

FY 1998 Minority Community Health Coalition Demonstration Program

The Minority Community Health Coalition Demonstration Grant Program is administered by the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS). The OMH was created in December 1985 with a mission to improve the health of racial and ethnic minority populations through policies and programs that will help to address the health disparities and gaps. Consistent with its mission, the OMH serves as the focal point within the Department for leadership, policy development and coordination, service demonstrations, information exchange, coalition and partnership building, and related efforts to address the health needs of racial and ethnic minorities.

The Minority Community Health Coalition Demonstration Program was developed in 1986 to promote the development of coalitions for the purpose of planning and coordinating services to reduce sociocultural and linguistic barriers to health care. The coalition approach is believed to be an effective strategy for health promotion and risk reduction among targeted minority populations, and is based on the premise that its use will result in interventions that are culturally sensitive, credible and more acceptable to the target population; that the project will address the health problem(s) within the context of related socioeconomic issues; and that the effort will contribute to overall community empowerment by strengthening indigenous leadership and organizations. In FY 1998 the Minority Community Health Coalition Demonstration Program focused on those health problem areas identified in the 1995 OMH Report to Congress, commonly referred to as the "7 + 4" health issue areas: cancer; cardiovascular disease and stroke; chemical dependency; diabetes; homicide, suicide and unintentional injuries; infant mortality; and HIV/AIDS; plus, access to health care; health professions personnel development; improved data collection and analysis; and cultural competency.

The 17 projects described in this fact sheet are funded for the three-year project period 7/1/98 through 6/30/01. The grants are administered by minority community-based organizations that have established coalitions with at least two other organizations/institutions, one of which is a health care facility. Each program is required to address at least one of the "7 + 4" health issue areas; however, grantees are also given flexibility to define and address health problems unique to their communities (e.g., asthma, sexually transmitted diseases, tuberculosis, female genital mutilation, immunization and tobacco use).

For additional information, please contact the Division of Program Operations, Office of Minority Health.

April 1999

**MINORITY COMMUNITY HEALTH COALITION DEMONSTRATION
PROGRAM GRANTS**

ALASKA: *Southeast Alaska Regional Health Consortium*, Sitka, AK

ARIZONA: *Little Singer Community School*, Winslow, AZ

CALIFORNIA: *Asian & Pacific Islander Wellness Center*, San Francisco, CA
Bienestar Human Services, Inc., Los Angeles, CA
El Concilio of San Mateo County, Burlingame, CA
Logan Heights Family Health Center, San Diego, CA

CONNECTICUT: *Urban League of Greater Hartford, Inc.*, Hartford, CT

FLORIDA: *Black on Black Task Force*, Gainesville, FL

HAWAII: *Ke Ola Mamo*, Honolulu, HI

KANSAS: *Center for Health and Wellness, Inc.*, Wichita, KS

MASSACHUSETTS: *Partners in Health*, Cambridge, MA

MICHIGAN: *Inter-Tribal Council of Michigan, Inc.*, Sault Ste. Marie, MI

MISSOURI: *Samuel U. Rodgers Community Health Center*, Kansas City, MO

PENNSYLVANIA: *Esperanza Health Center, Inc.* Philadelphia, PA
Giving of Self Partnership, Inc., Philadelphia, PA

SOUTH DAKOTA: *Porcupine Clinic Health Board*, Porcupine, SD

WEST VIRGINIA: *Tug River Health Association, Inc.*, Gary, WV

ALASKA

Southeast Alaska Regional Health Consortium

222 Tongass Drive

Sitka, AK 99835

Phone: (907) 966-8739

Fax: (907) 966-8707

Title: **Southeast Alaska Coalition for Health Improvement**

Grant No.: D52MP98095

Project Director: Stephanie Aird

Target Population: Alaska Native, American Indian

Health Issues: Diabetes, Access to Health Care, Data Collection/Analysis

Age Group: Adults

The primary goals of the *Southeast Alaska Coalition for Health Improvement* project are to increase the number of Native Alaskans in the target areas who are screened, diagnosed and treated for diabetes, and to decrease the levels and types of behavioral risk factors for the disease. The Coalition consists of the PATCH (Planned Approach To Community Health) groups in the communities of Angoon, Kake, Klawock, and Craig; Village Community Health Aides in those communities, as well as Hydaburg; and the Village Community Family Service Workers in all of the above named communities. The approach to meet the goals is locally driven, managed and implemented by Southeast Alaska Native professionals and volunteers who live in each of the five target villages. The project focuses on community mobilization for health screenings and follow-up, and community-based health education to reduce risk factors and encourage healthier lifestyles based on traditional principals. The PATCH Core Groups and Coordinators are responsible for conducting health risk appraisals. Village clinics and health aide staff provide medical follow-up and education. The Community Family Service workers provide mental health follow-up and counseling. Community education activities are provided based on specific local interests and prevalence of behavior risk factors.

ARIZONA

Little Singer Community School

P.O. Box 310

Winslow, AZ 86047

Phone: (520) 526-2950

Fax: (520) 526-2068

Title: **Diné Family Health and Wellness**

Grant No.: D52MP98164

Project Director: Mark Sorensen, PhD

Target Population: American Indian

Health Issues: Chemical Dependency, Diabetes, Domestic Violence

Age Group: Infants to Elderly

The goal of the *Diné Family Health and Wellness* Project is to treat and prevent problems associated with diabetes, domestic violence and alcohol abuse among families living in the southwestern Navajo area. The Coalition consists of the Little Singer Community School, Northern Arizona University, the Navajo Area Indian Health Service, and the Winslow Service Unit. The Coalition's approach to attaining its goal is developing and implementing a combination of clinical preventive and referral service activities, disseminating information, and sponsoring healthy physical activities in the context of traditional Navajo values of kinship and harmony. For all of the targeted health issues, the project provides a culturally adapted environment in which there is a balance between health-enhancing activities and medical treatment. The project offers community-wide education in the management and prevention of diabetes. Screening is available to all community members at the Wellness Center on the Little Singer School campus, as well as at the Indian Health Center facility in Leupp. Behavior health counseling and training services emphasize the prevention of child abuse, teen suicide and spousal abuse. The project's approach to alcohol abuse treatment incorporates both the medical and public health models into a Navajo-specific traditional healing model.

CALIFORNIA

Logan Heights Family Health Center

1809 National Avenue
San Diego, CA 92113
Phone: (619) 234-8171
Fax: (619) 237-1856

Title: **Steps to Change: An HIV Prevention Case Management Model for Minority Injection Drug Users**

Grant No.: D53MP98062

Project Director: Fran Butler-Cohen

Target Population: Black/African American, Hispanic/Latino, Asian, American Indian

Health Issues: HIV/AIDS, Chemical Dependency

Age Group: Adolescents and Adults

The primary goals of the *Steps to Change* project are to increase the target population's knowledge about HIV/STD prevention services and to provide intensive prevention case management services to minorities at high risk for HIV and STDs (with a focus on injection drug users and their partners). The three clinic partners (Logan Heights Family Health Center, East County Community Clinic, Inc., and Vista Community Clinic) each employ outreach workers who make initial contact with members of the target group on the street, in parks and at social service sites. The outreach workers work closely with the prevention case managers at each clinic, maintaining logs of contacts and referrals. The prevention case managers conduct client assessments and work closely with those eligible for the program to develop individual behavior objectives as part of an overall prevention plan. Prevention case management clients are asked to participate in a schedule of STD tests and treatment provided by the San Diego County Health and Human Services Agency. HIV risk reduction education is provided at least twice monthly and includes education about STDs, HIV, support for lifestyle changes, and referrals to medical, psychosocial and substance abuse treatment services.

CALIFORNIA

El Concilio of San Mateo County

1419 Burlingame Avenue, Suite N
Burlingame, CA 94010
Phone: (650) 373-1080
Fax: (650) 373-1090

Title: **Nuestro Canto de Salud Health Coalition**

Grant No: D53MP98059

Project Director: Ortensia Lopez

Target Population: Hispanic/Latino

Health Issues: Diabetes, HIV/AIDS, Chemical Dependency

Age Group: Adults and Elderly

The goals of the *Nuestro Canto de Salud Health Coalition* project are to reduce the incidence of diabetes, HIV/AIDS and chemical dependency among Latinos and to build the capacity of Latino communities and organizations to carry out similar projects. The four project partners in the *Nuestro Canto de Salud Health Coalition* (El Concilio, San Mateo Health Services Agency, El Centro de Libertad and Gente Latina de Ambiente) combine to utilize a three-tiered service strategy of community outreach, health screening, and case management. This project expands an existing Promotore program in which community members are recruited and trained to conduct community, street and other outreach on health problems affecting Latinos. Outreach programs are linked to the promotion of diabetes screening and HIV testing/counseling at the Mobile Health Clinic and El Centro's treatment and HIV testing program. The case management component assists Latinos with more severe diabetes and associated problems, and offers more intensive follow-up with treatment and treatment referrals for Latinos with HIV/AIDS and chemical dependency problems. Coalition staff and Promotores act as cultural brokers to help case management clients gain access to improved testing, health care and treatment services.

CALIFORNIA

Bienestar Human Services, Inc.

5326 E. Beverly Boulevard

Los Angeles, CA 90022

Phone: (213) 727-7896

Fax: (213) 727-7985

Title: **Life Preserver/Salvavida**

Grant No: D53MP98137

Project Director: Oscar De la O

Target Population: Black/African American, Hispanic/Latino, Asian

Health Issues: HIV/AIDS, Access to Health Care

Age Group: Adults (18 to 50)

The *Life Preserver/Salvavida* project is conducted by the Gay Men of Color Consortium which consists of four member agencies: Bienestar Human Services, Inc.; the Asian Pacific AIDS Intervention Team; the AIDS Prevention Team of the National Black Gay and Lesbian Leadership Forum; and the Minority AIDS Project. The Oasis Clinic of Charles R. Drew Medical School also participates in the project. The project goal is to reduce AIDS incidence and AIDS death rates among African American, Latino and Asian/Pacific men in Los Angeles who are gay, bisexual or men-who-have-sex-with-men (who do not self-identify as gay or bisexual). Each of the consortium agencies provide outreach and referral activities; promotion of treatment; and treatment education. Outreach and referral activities are conducted by a combination of volunteer/part-time workers at the consortium agencies. Clients in need of medical treatment are referred to the Oasis clinic or health facilities with which the agencies work. Program clients are provided one-to-one counseling and assistance in completing treatment plans which identify action steps necessary to access treatment and adhere to treatment regimens. Participants' compliance with individualized treatment action plans is monitored through quarterly follow-up by project staff.

CALIFORNIA

Asian & Pacific Islander Wellness Center

730 Polk Street, Fourth floor

San Francisco, CA 94109

Phone: (415) 292-3400, ext. 339

Fax: (415) 292-3404

Title: **Tenderloin Asian Health Improvement Project**

Grant No.: D53MP98135

Project Director: John Manzon-Santos

Target Population: Asian

Health Issues: HIV/AIDS, Access to Health Care, Cultural Competency

Age Group: Adults (18 to 45)

The *Tenderloin Asian Health Improvement Project* is a coalition of the Asian and Pacific Islander Wellness Center, Southeast Asian Community Center, Tom Waddell Health Clinic and Lyon Martin Women's Services. The coalition targets monolingual and limited-English-proficient Asian male to female transgender sex workers and Asian female sex workers in the Tenderloin district of San Francisco for HIV/STD screening, preventive case management and access to primary health care. The primary goal of this project is to promote the health (with an emphasis on sexual health), well being, and self-sufficiency of hard to reach Asian populations in the service area. An additional goal of the project is to improve service access and competence for Asian populations in the area. The project utilizes four interventions: Mobile Comprehensive Case Management; life skills classes; outreach; and cultural sensitivity trainings. The prevention case manager conducts outreach, provides individual case management, and escorts clients to the health facility; a seamless referral from outreach to primary health care. This model addresses barriers to utilization by providing advocacy, escort and interpretation services. The Mobile Comprehensive Case Management model also includes enrollment in English language classes, job training and life skills class.

CONNECTICUT

Urban League of Greater Hartford, Inc.

1229 Albany Avenue
Hartford, CT 06112
Phone: (860) 527-0147
Fax: (860) 249-1563

Title: **Community Health Coalition: Diabetes Outreach, Screening and Access to Quality Care**

Grant No.: D52MP98046

Project Director: Richard J. Gruber

Target Population: Black/African American, Hispanic/Latino

Health Issues: Diabetes, Access to Health Care, Cultural Competency

Age Group: Adults, Elderly

The goals of the *Community Health Coalition: Diabetes Outreach, Screening and Access to Quality Care Project* are to: identify individuals with undiagnosed or uncontrolled diabetes in the target populations utilizing culturally appropriate outreach strategies and methods; refer clients to appropriate diabetes care centers and primary care providers for enhanced self care and nutrition education; and follow-up on referrals to ensure maintenance of treatment regimens and reinforcement of self care education. The Coalition is composed of the Hartford Health Department, the Urban League of Greater Hartford, the Hispanic Health Council, St. Francis Hospital and Medical Center, Hartford Hospital, and the two federally designated community health centers in Hartford. The project coordinates community-based activities to address outreach and community education, screening, referral advocacy, training of peer volunteers, diversity training, and training in standards of care. Other activities include health fairs and diabetes screening events in churches, schools, elderly centers, homeless shelters, mental health clinics, malls and shopping plazas, parks and hair salons. Clients receive formal self care diabetes education in the areas of management, nutrition, exercise and skin/foot care, and comorbidities. Case-management is provided on a limited basis to assist patients in accessing such services as health and mental health care, health insurance, medications, and transportation. A multimedia social marketing strategy will be developed as a method to educate the minority community about the risk and prevention of complications resulting from diabetes.

FLORIDA

Black on Black Task Force

P.O. Box 2607

Gainesville, FL 32602

Phone: (352) 955-5958

Fax: (352) 955-5529

Title: **Coalition for Minority Health**

Grant No.: D53MP98073

Project Director: Rosa B. Williams

Target Population: Black/African American

Health Issues: Asthma, Diabetes, HIV/AIDS

Age Group: Children, Adolescents, Adults

The *Coalition for Minority Health* is composed of: the Black on Black Task Force; Community Health Center at Eastside; Shands Healthcare; Alachua County Department of Health; Community Partners for Health Promotion, Department of Juvenile Justice, District III; Corner Drug Store Inc.; and North Central Florida AIDS Network. Its goals are to encourage health promotion and risk reduction and to reduce negative effects of chronic health problems (asthma, diabetes/obesity and HIV/AIDS) among the target population. The coalition coordinates efforts of health providers, the school board, churches and members of the minority community to develop a community-based system as a teaching model for middle and elementary school-age youth. The components of the program include: the Asthma Partners Program which uses a culturally sensitive curriculum that includes basic information about asthma, warning signs and what starts attacks, medication and the use of inhalers, personal action plan for self-help and emergency plans; the After School Diabetes/Obesity Program, which offers nutrition groups, group sessions, and exercise classes; and the Celebrate Life Program which focuses on HIV/AIDS education and prevention.

HAWAII

Ke Ola Mamo

1130 Nimitz Highway, A-221

Honolulu, HI 96817

Phone: (808) 533-0035

Fax: (808) 531-6949

Title: **Ho'oikaika No Wai'anae (Making Waianae Strong)**

Grant No.: D53MP98165

Project Director: Carol Odo

Target Population: Native Hawaiian

Health Issues: Cardiovascular Disease and Stroke, Diabetes

Age Group: Adolescents and Adults

The members of the *Ho'oikaika No Wai'anae (Making Waianae Strong)* coalition (Ke Ola Mamo, Native Hawaiian Health Care System for the Island of Oahu, Waianae Coast Comprehensive Health Center and Standing in the Gap for Youth) have developed a program with a goal of reducing the risk factors for cardiovascular disease/stroke and diabetes through early detection, nutrition, exercise, case management and follow-up. The program is made up of three interrelated components: screening clinics for heart disease, hypertension and diabetes; fitness and nutrition workshops; and exercise groups. Participants recruited into one component are encouraged to participate in the other two. Central to the Ho'oikaika program is prevention and/or control of the complex of symptoms that result in stroke and diabetes complications and heart disease; and promotion of healthy living through nutrition education and assisted exercise. Early detection clinics and health days are held at such locales as Hawaiian churches and civic club events. The program is based on a pilot project in which outcomes of lower blood pressure, weight loss and increased strength and endurance were evident after six months.

KANSAS

Center for Health and Wellness, Inc.

1148 S. Hillside, Suite 11
Wichita, KS 67211
Phone: (316) 689-5255
Fax: (316) 691-6716

Title: **Northeast Wellness Coalition**

Grant No.: D52MP98091

Project Director: Arneatha Martin

Target Population: Black/African American

Health Issues: Cardiovascular Disease/Stroke, Diabetes, Infant Mortality

Age Group: All

The *Northeast Wellness Coalition*, comprised of the Center for Health and Wellness, Inc., the Wichita Black Nurses Association, and the Community Development Coalition, Inc., seeks to decrease the incidence of chronic diseases affecting the community; reduce the infant mortality rate; and increase access to health care services. The project is designed to empower African American families at risk for cardiovascular disease/stroke and diabetes to change high risk behaviors (lack of exercise; poor diet/nutrition; tobacco/alcohol/drug use), subsequently adopting healthier lifestyles and practices that will improve the overall health of the community. A curriculum has been developed to train African American outreach workers to specialize in wellness education and community outreach. The Coalition also focuses on health care services for identified high-risk populations (the elderly, childbearing families and children). Primary health care services are provided by the Center. A family practice physician teamed with an advanced practice nurse provides diabetes assessment/management and education; hypertension screening/management and education; women health assessment/management and education; prevention and wellness education programs; pediatric assessment/management and education; and a community center for health education. Transportation and child care services for clients are provided. The project also addresses issues related to single parenting, low self-esteem, and assumption of more responsibility by clients for the management of their own health care.

MASSACHUSETTS

Partners in Health

113 River Road
Cambridge, MA 02139
Phone: (617) 661-4564
Fax: (617) 661-2669

Title: **Comprehensive Community-Based HIV Prevention and Treatment in Roxbury, MA: Implementation of a Program to Improve Health Outcomes**

Grant No.: D53MP98142

Project Director: Jim Yong Kim, MD, PhD

Target Population: Black/African American, Hispanic/Latino

Health Issues: HIV/AIDS

Age Group: Adolescents, Adults

The Comprehensive Community-Based HIV Prevention and Treatment in Roxbury, MA: Implementation of a Program to Improve Health Outcomes project confronts HIV and AIDS in the community in a comprehensive and culturally-sensitive manner. The coalition is composed of Partners In Health, its sister organization Soldiers Of Health, the Brigham and Women's Hospital, Casa Iris, and Brookside Community Health Center. The primary goals of the project are to develop and implement a comprehensive HIV education and prevention program and to improve access to quality medical services. The coalition addresses these goals through the use of community health workers and coalition members to conduct intensive outreach in the neighborhood for people with HIV/AIDS, other STDs, and people at high-risk of HIV. The prevention and treatment components uses an established network of community residents trained in HIV prevention and community-based interventions for people living with HIV disease. The network is based on a model of neighbor-to-neighbor outreach. A team of professionals designs and disseminates prevention information through a variety of sources. High-risk groups, including adolescents and injection drug users, receive a more intense intervention. Persons with HIV and AIDS are identified by coalition members and paired with outreach workers who assist in accessing health and social services needs.

MICHIGAN

Inter-Tribal Council of Michigan, Inc.

405 E. Easterday Avenue
Sault Ste. Marie, MI 49783
Phone: (906) 632-6896
Fax: (906) 632-1388

Title: **“Mmin-nuh-gah-dah”–Healthy Heart Program, Native Health Coalition**

Grant No.: D52MP98077

Project Director: Sylvia A. Murray

Target Population: American Indian

Health Issues: Cardiovascular Disease/Stroke, Diabetes, Cultural Competency

Age Group: Adolescents

The goal of the *“Mmin-nuh-gah-dah”-- Healthy Heart Program, Native Health Coalition* project is to increase the level of effective intervention for cardiovascular disease and diabetes and to provide outreach and advocacy for the target population in procuring culturally competent health care. The Inter-Tribal Council of Michigan, Inc., Michigan Indian Tribes and the Saint Mary’s Heartside Clinic, are collaborating to establish a system of early screening for cardiovascular disease and diabetes for Native Americans living in metropolitan Grand Rapids in west central Michigan. The project targets the 1,311 identified enrolled tribal members from the constituent tribes in the Coalition who reside in the target geographical area. Subsequent to screening, clients receive assistance with entry into treatment. The Coalition also provides cultural competency training to health care providers at Heartside Clinic, and to their associates. Other activities include development of outreach materials (flyers, articles for tribal and local newsletters, posters, personal letters), and participation in health fairs and community events (Pow Wows, Native Art Fairs, school functions).

MISSOURI

Samuel U. Rodgers Community Health Center, Inc.

825 Euclid
Kansas City, MO 64124
Phone: (816) 889-4756
Fax: (816) 474-6475

Title: **Panda Place Coalition**

Grant No.: D52MP98053

Project Director: Warren Brodine

Target Population: Black/African American, Hispanic/Latino, Asian

Health Issues: Cardiovascular Disease, Diabetes, Child Abuse and Neglect

Age Group: All

The *Panda Place Coalition* aims to increase healthy behaviors and reduce the incidence of diabetes, cardiovascular disease, and child abuse and neglect in the target population. The Coalition consists of the Samuel U. Rodgers Community Health Center, Inc., Whatsoever Community Center, McCoy School, Don Bosco Centers, and the Kansas City Free Health Clinic. The project is designed to promote the advantages of healthy behavioral decisions in the following key areas: diet, exercise and weight reduction; general stress reduction; and alcohol consumption and cigarette smoking. Project activities include one-on-one health outreach through door-to-door contacts, referrals from the Panda Place Wellness Center and attendance at group activities; health-related group activities; community mobilization; and connection to existing health resources. Four health fairs are sponsored each year and other group activities are conducted at churches, community centers, non-profit agencies and the McCoy School. The project attempts to create an awareness of the identified health problems and foster commitment to action at such a level in the target population that the risk-reduction decisions by individual members are reinforced. At least 40 business and community organizations which serve the target area have committed, to promote health education among their customers and members through word-of-mouth, educational programs, flyers, newsletter articles, and health screening.

PENNSYLVANIA

Giving of Self Partnership, Inc.

1301 West Ruscomb Street
Philadelphia, PA 19141
Phone: (215) 324-8990
Fax: (215) 329-8730

Title: **Community Coalition for Minority Children's Health**

Grant No.: D52MP98038

Project Director: Rev. Harold Blount

Target Population: Black/African American, Hispanic/Latino, Asian

Health Issues: Pediatric Asthma, Infant Mortality

Age Group: All

The *Community Coalition for Minority Children's Health* seeks to improve the health status of infants and school age children in Logan County. The Coalition members (Giving of Self Partnership, Albert Einstein Medical Center, La Salle University Neighborhood Nursing Center, and the School District of Philadelphia) focus on economic development, health care, and human services. The goals of the project are to: assist women to achieve healthy pregnancies and take an active role in their babies' health during the first year of life to decrease infant mortality; and assist families affected by pediatric asthma to partner effectively with the primary care providers in asthma management in order to increase the quality of life for children with asthma. Activities include community-based assessment (including insurance, immunization, and nutritional status; utilization of primary care; and barriers to health maintenance); education; outreach services; and linkage for the target population to socially and culturally appropriate health care interventions (e.g., referral, individual and group educational sessions, home visits, and case management). Pregnancy testing and counseling are provided free for anyone requesting this service. The prenatal and parenting program provides case management services (health care plans, parenting education and home environment assessment) for women who are pregnant or parenting children under 12 months of age.

PENNSYLVANIA

Esperanza Health Center, Inc.

2927 N. Fifth Street
Philadelphia, PA 19133
Phone: (215) 634-4673
Fax: (215) 634-5298

Title: **Healthy Living 2000**

Grant No.: D53MP98058

Project Director: Patrick Pulliam, MD

Target Population: Hispanic/Latino

Health Issues: HIV/AIDS, Asthma, Lead Poisoning
Age Group: Children,
Adults

The *Healthy Living 2000* project's overall goal is to educate and empower 100 asthmatic children, their families and others to reduce or eliminate risk factors relating to HIV/AIDS, asthma and lead poisoning. The Coalition members consist of Esperanza Health Center, Nueva Esperanza, and the School District of Philadelphia. The Coalition's mission seeks a holistic approach to improve the health status of Latino children, their families and friends through environmental risk-reduction education and linkages with community health centers, housing associations, and other social networking agencies. The project activities are centered around interactive educational workshops, developing relationships with participants, providing intervention services, and establishing linkages with community agencies and churches for ongoing treatment and support. Educational "Healthy Living" workshops are conducted for the target group, their families and school personnel. Attendees of the workshops are trained to recognize, control, and eliminate environmental health hazards that trigger or exacerbate asthma episodes and put them at risk for lead poisoning or contracting HIV/AIDS. The community housing representative provides free in-home lead paint assessments to those enrolled in the program, while the mortgage

SOUTH DAKOTA

Porcupine Clinic Health Board

P.O. Box 99

Porcupine, SD 57772

Phone: (605) 867-5655

Fax: (605) 867-1208

Title: **Wakanyeja Blihel Wicayapi (Strengthening Our Children)**

Grant No: D52MP98086

Project Director: Mary Tobacco

Target Population: American Indian

Health Issues: Chemical Dependency, Diabetes, Access to Health Care

Age Group: Infants, Children and Adolescents

The Porcupine Health Board has formed a coalition with the Oglala Lakota College Department of Nursing, the Oglala Sioux Tribe Health Education Program and the Oglala Sioux Tribe Community Health Representative with the overall goal of helping the Oglala Lakota people live longer, healthier lives. Specifically, the *Wakanyeja Blihel Wicayapi* program seeks to significantly reduce preventable morbidity on the Pine Ridge Reservation. The project conducts school-based health screenings in the community. The screenings, which focus on risks for diabetes, high blood pressure and chemical dependency, are conducted by community people and supervised by a pediatrician. The trained community workers in turn conduct focused home visits to families with high risk children. The findings of the health screenings are presented in a supportive way, emphasizing that risks can be decreased by modest, positive lifestyle changes. After the initial home visits, Gathering of Native Americans retreats are offered in each of the reservations nine districts for those families at risk for chemical dependency. Weekly radio broadcasts provide appropriate health information from the reservation's station which features bilingual announcers and traditional Lakota music.

WEST VIRGINIA

Tug River Health Association, Inc.

U.S. Route 103 - Supply Street

P.O. Box 507

Gary, WV 24836

Phone: (304) 448-2101

Fax: (304) 448-3217

Title: **McDowell County Minority Community Health Project**

Grant No.: D52MP98120

Project Director: Charles Johnson, III

Target Population: Black/African American

Health Issues: Cardiovascular Disease/Stroke, Cancer, Infant Mortality

Age Group: All

The primary goals of the *McDowell County Minority Community Health Project* are to focus on improvement in maternal and infant health issues, cardiovascular/ cerebrovascular disease (stroke) and malignant neoplasms (cancer) fatalities. The four partners (Tug River Health Association, Inc., Welch Emergency Hospital, McDowell County Board of Education, and Council of Southern Mountains) joined together to impact upon the overall health and well-being of the Black population of McDowell County. The project's concept is a comprehensive educational, outreach, case management, and services linkage design. Activities are designed to create awareness, identify and link existing services to the at-risk population, and garner community support. They include comprehensive community and school-based education to create awareness of maternal and infant health issues, cardiovascular disease/stroke and cancer fatalities; outreach to identify and assess the health status of the targeted population; and service linkage of the target population to existing care providers to assure that necessary care, health maintenance and screening interventions are received. Individuals are identified and enrolled into age and sex specific screening programs, for the purpose of early detection of cancer and to reduce subsequent incidences of death. Other services include family planning, prenatal care, and immunizations. Health awareness activities involve publishing health articles in the County newspaper; producing public radio health information shows; and conducting community and church based health education programs.