Community Focused Eliminating Health Disparities Initiative
2015—2017 Fiscal Biennium Report

Session Law 2015-241, Section 12E.3.(d)

Report to

The Joint Legislative Oversight Committee on

Health and Human Services

By

North Carolina
Department of Health and Human Services

October 1, 2017

Reporting Requirements

SECTION 12E.3.(d) By October 1, 2017, the Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on funds appropriated to the CFEHDI for the 2015-2017 fiscal biennium. The report shall include specific activities undertaken by grantees pursuant to subsection (a) of this section to address large gaps in health status among North Carolinians who are African-American and other minority populations in this State and shall also address all the following:

1. Which community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks received CFEHDI grants-in-aid.
2. The amount of funding awarded to each grantee.
3. Which of the minority populations were served by each grantee.
4. Which community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks were involved in fulfilling the goals and activities of each grant-in-aid awarded under this section and what activities were planned and implemented by the grantee to fulfill the community focus of the CFEHDI program.
5. How the activities implemented by the grantee fulfilled the goal of reducing health disparities among minority populations and the specific success in reducing particular incidences.

Executive Summary

The Community Focused Eliminating Health Disparities Initiative (CFEHDI) previously focused on the use of preventive measures to support healthy lifestyles for African Americans, Hispanics/Latinos, and American Indians as a way to close the gap in health disparities between minority populations and the white population. Recent legislation (HB 200 Section 10.21 (S.L. 2011-145) supports the need to modify the existing program and include an emphasis on medical home services delivered by the NC health care system. Eligible applicants include faith-based organizations, community-based organizations, hospitals, local Community Care of North Carolina (CCNC) networks, hospitals and local health departments (LHD). These applicants shall work collaboratively to ensure implementation of an evidence-based medical home model to close the gap in the health status of African Americans, Hispanics/Latinos, and American Indians as compared to the white population. The eight focus areas are: Heart Disease, Stroke, Diabetes, Obesity, Asthma, HIV/AIDS/STDs, Cancer and Infant Mortality. Eligible applicants shall select one or more of these chronic illnesses or conditions specific to the applicant's geographic area as the basis for applying for grant-in-aid under this initiative.

Approximately $2.5 million in either State funds or Preventive Health Block Grant funds were used to provide a maximum of twelve (12) grants-in-aid to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons in SFY 2015-2016. Individual grants may not exceed $300,000 annually. No more than four (4) grants-in-aid were awarded to applicants located in the urban and rural areas of the Western, Piedmont, and Eastern areas of North Carolina (map is enclosed). The exact total number of awards and amount funded depended on the number of quality applications received, the appropriateness of the applicants' proposed goals, objectives, strategies and activities, and the likelihood of the success of the proposed project.

Grantees awarded funds under this RFA received a 12-month contract which represents the grant period for Year 1; June 1, 2015 to May 31, 2016. Funds for Year 2 were not awarded and this program was eliminated, with funds now being used to carry out the statewide Minority Diabetes Prevention Program. Overall, CFEHDI grantees provided services to 15,148 unduplicated participants. These services not only addressed prominent health issues in our minority communities, but confronted the social determinants of health, which create barriers to obtaining necessary health services. The services offered included: evidence-based health management programs, interpretation services, transportation services, educational outreach, screenings, and providing culturally competent care.

Background

The Office of Minority Health and Health Disparities (OMHHD) was established by the North Carolina General Assembly in 1992. The mission of OMHHD is to promote and advocate for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina. The North Carolina Office of Minority Health and Health Disparities (NC OMHHD) defines health disparities as "*differences or inequalities in health that exist between whites and racial/ethnic minorities*."

The NC Office of Minority Health and Health Disparities, in collaboration with the State Center for Health Statistics, first published a report on "Racial and Ethnic Differences in Health" in May 2004. The previous and current "Health Disparities Report Card" (2010) (www.ncminorityhealth.org) revealed major disparities in health status for minority populations in North Carolina. Among many indicators of health, data from the Health Disparities Report Card showed that significant gaps in health status continually exist in the following areas: Heart Disease, Stroke, Diabetes, Obesity, Asthma, HIV/AIDS/STDs, Cancer and Infant Mortality. These public health conditions are the focus areas of this RFA.

According to the Health Disparities Report Card (2010) in North Carolina,

- The percent of Hispanic/Latinos, African American and American Indian families living below the federal poverty level is 3 times higher than that of white families.
- African Americans continue to die of AIDS at a rate of 13.7 times more than that of the white population.
- American Indians and African Americans are 2 times more likely to die from diabetes than the white population.
- The percent of heart disease deaths of Hispanic/Latinos, African Americans and American Indians per 100,000 population are on avearge 1.2 times higher than that of the white poluation.
- African Americans continute to die of strokes at a disparity ratio of 1.5 times greater than the white population.
- African-American children under the age of 18 continue to be diagnosed with asthma 1.4 more times than the white population.
- African Americans and American Indians are 1.2 times more likely to be overweight or obese than the white population.
- African American and American Indian babies die at greater than 2.0 disparity ratio.
- African-American men are 2.8 times more likely to die from prostate cancer than the white population.

Chronic diseases (e.g., asthma, heart disease, obesity, diabetes) are defined as a health condition that lasts more than 12 months, or at the time of diagnosis is likely to have a duration of greater than 12 months. Overwhelming evidence indicates that chronic diseases disproportionately affect racial and ethnic minorities, including individuals from lower socioeconomic classes, women, and children, and may affect these individuals' ability to attain and maintain their health. Thus, there is an urgent need for evidence-based strategies focused on the elimination or reduction of health disparities among minority families, adults and children. Numerous reports have documented that low-income Black and Hispanic children are more likely to be uninsured, and less likely to have access to regular preventive and clinical health care services. Experts note that additional barriers to receiving preventive and clinical services include poverty, inadequate or lack of insurance, limited transportation, lack of cultural sensitivity among health care providers and access to health care providers within certain geographic areas.

The Community Focused Eliminating Health Disparities Initiative (CFEHDI) provided 12 grants-in-aid to reduce health disparities among African-Americans, Hispanic/Latinx, and American Indians. Based on the RFA, individual grants were not to exceed $300,000 annually, but an executive decision was made to not fund sites past a threshold of $240,000 so funds could be distributed equitably for all grantees. Below, in Table 1, you can see the name of each organization, the type of organization, their focus area(s), the location(s) and population(s) each served, as well as their award amount per year.

Table 1

CFEHDI Grantee Profiles 2015—2017

ORGANIZATIONS	TYPE OF ORGANIZATION	FOCUS AREA	COUNTIES	POPULATION SERVED	REGION	AWARD AMOUNT
AccessCare	CCNC	Diabetes and Heart Disease	Alamance, Caswell, Orange and Chatham	African American and Hispanic/Latinos	Piedmont	$225,000.00
Appalachian Regional Healthcare System, Inc.	Hospital	Cancer, Diabetes, Obesity, Heart Disease and Stroke	Avery and Watauga	Hispanic/Latinos	Western	$131,906.00
Buncombe County Health Department	LHD	Cancer, Diabetes, HIV/AIDS/STDS, Obesity, Heart Disease, Stroke and Asthma	Buncombe	African American, Hispanic/Latinos, and American Indian	Western	$240,000.00
Community Health Interventions & Sickle Cell Agency, Inc.	CBO	Diabetes and HIV/AIDS/STDs	Cumberland and Hoke	African American	Eastern	$226,793.00
Lincoln Community Health Center, Inc.	CBO	Diabetes and HIV/AIDS/STDs	Durham	African American	Piedmont	$240,000.00
Lumbee Nation Tribal Programs, Inc.	CBO	Cancer, Diabetes, and Obesity	Robeson, Scotland, Hoke, and Cumberland	American Indian	Eastern	$240,000.00
Margaret R. Pardee Memorial Hospital	Hospital	Diabetes	Henderson	African American and Hispanic/Latino	Western	$228,636.00
Onslow County Health Department	LHD	Diabetes	Onslow	African American and Hispanic/Latinos	Eastern	$238,101.00
Scotland Community Health Clinic	CBO	Diabetes, Obesity, Heart Disease, and Stroke	Scotland	African American, Hispanic/Latino and American Indian	Piedmont	$108,751.00
Southern Piedmont Community Care Plan, Inc.	CBO	Heart Disease	Cabarrus and Rowan	African American and Hispanic/Latinos	Western	$240,000.00
Wake County Medical Society-Community Health Foundation	CCNC	Diabetes, Obesity, Heart Disease and Stroke	Wake and Johnston	African American and Hispanic/Latinos	Piedmont	$240,000.00
Wayne County Health Department	LHD	Diabetes, HIV/AIDS/STDs, Obesity, Heart Disease, and Stroke	Wayne	African American and Hispanic/Latinos	Eastern	$188,807.00
					TOTAL:	**$2,547,994.00**

Table 2 provides the community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks were involved in fulfilling the goals and activities of each grantee.

Table 2

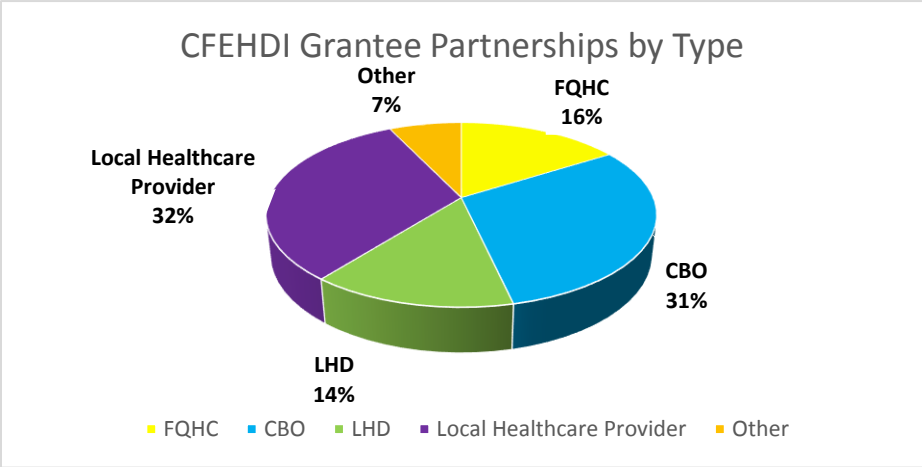
Partnerships

AccessCare	Chatham County Public Health Department University of North Carolina at Chapel Hill Orange County Health Department Piedmont Health Services
Appalachian Regional Healthcare System	Appalachian Healthcare Project Appalachian Regional Medical Associates Community Care Clinic High Country Community
Buncombe County Health and Human Services	YWCA Asheville Buncombe Institute of Parity Achievement Mission Health Community Care of Western NC Asheville Public Housing
Community Health Inventions & Sickle Cell Agency	Southern Regional Area Health Education Center Stedman-Wade Health Services Cumberland County Health Department Fayetteville State University Disparities Research Center Cape Fear Valley Health System Carolina Collaborative Community Care North Carolina Prevention and Control Program and Communicable Disease Branch
Lincoln Community Health Center	Duke University Health Systems Northern Piedmont community Care Partnership for a Healthy Durham Durham County Department of Public Health University of North Carolina at Chapel Hill Project Access

Partnerships

Lumbee Nation Tribal Programs	Robeson County Department of Health Lumbee Tribe of North Carolina Robeson Healthcare Corporation Hoke County Lumbee River Council of Aging (NC Division of Aging)
Margaret R. Pardee Memorial Hospital	YMCA of Western North Carolina Henderson County Department of Public Health Blue Ridge Community Health Services
Onslow County Health Department	Onslow County Department of Social Services Onslow County Senior Services Onslow Memorial Hospital Caring Community Clinic Cape Fear Health Net
Scotland Community Health Clinic	Scotland Healthcare System Scotland County Health Department and Cooperative Extension
Southern Piedmont Community Care Plan	Cabarrus Health Alliance Cabarrus Rowan community Health Centers Community Free Clinic
Wake County Medical Society	Johnston County Health Department First Missionary Baptist church Johnston UNC Healthcare The Foundation of Raleigh Fellowship
Wayne County Health Department	Wayne Memorial Hospital Wayne Action Team for Community Health Wayne County Cooperative Extension Goldsboro YMCA Wayne county Services on Aging

This table illustrates that the CFEHDI grantees, collectively, worked with over 57 partner organizations, including: 9 FQHCs, 17 CBOs, 8 LHDs, 18 local healthcare providers and 4 other community organizations.

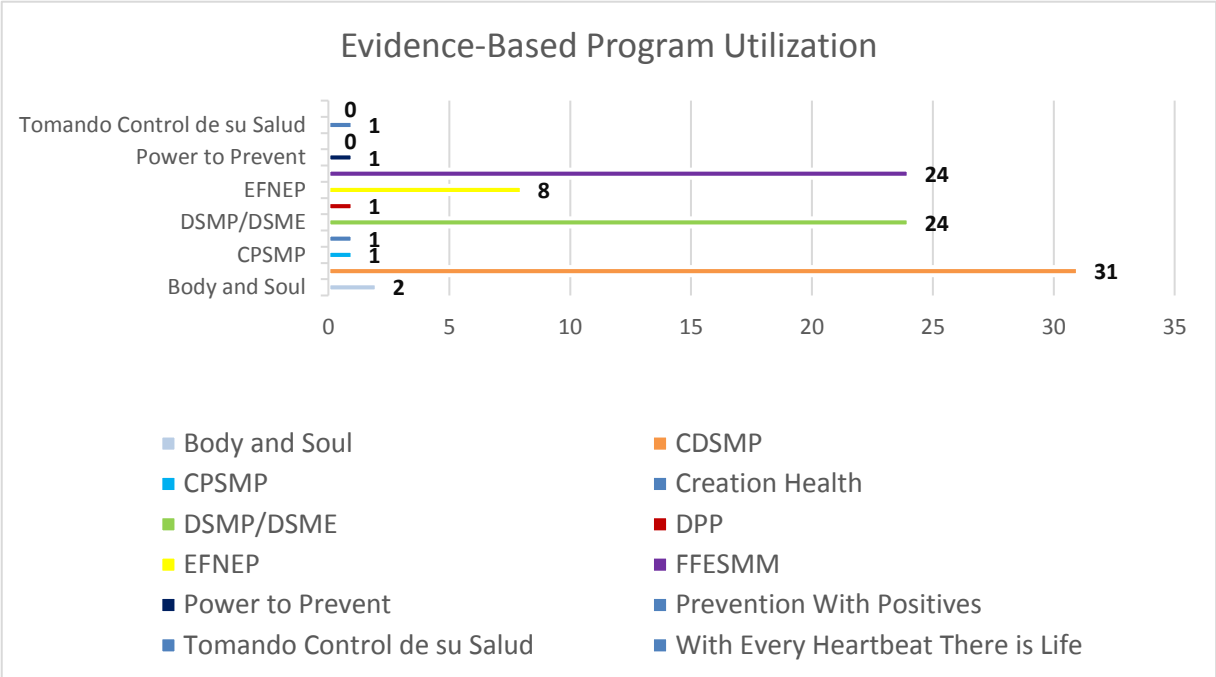


Collective Efforts

Outlined below is a summary of the efforts of the twelve grantees, including specific activities they undertook to address/reduce health disparities. Those latter efforts included teaching evidence-based disease management courses, referring participants to a patient centered medical home (PCMH) or primary care physician (PCP), interpretation services, transportation services, screenings and educational outreach.

Evidence-Based Programs

Evidence-based programs allowed the grantees to help reduce health disparities by teaching disease self-management and prevention. The evidence-based program component of CFEHDI was met with the proposed implementation of the 12 different programs, which can be found in the chart below. In total, the grantees had 1,333 participants complete their evidence-based programs. Some grantees offered one program type, while others offered multiple types. Programs could be offered once a year or multiple times a year. The average grantee offered more than 2 types of programs. The most common program offerings were Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program, (DSMP/DSME), and Faithful Families Eat Smart and Move More (FFESMM.) These evidence-based programs were provided an average of 7.75 times a year. (Medical Nutrition Therapy (MNT) was an outlier, as only one grantee provided this therapy consisting of one session per participant. This allowed MNT to be provided 449 times, which is considerably more times than the other programs because the other programs typically consisted of 6 to 9 sessions.) In the graph below, titled Evidence-Based Program Utilization, are all the programs provided by the CFEHDI grantees and the number of times each program was provided.



Faith-Based Outreach
Pastor-led preventative health messages were used by 4 grantees to provide information about healthcare resources, events, and promote healthy living to their target populations. There were 33 health messages extended to a total of 2288 people.

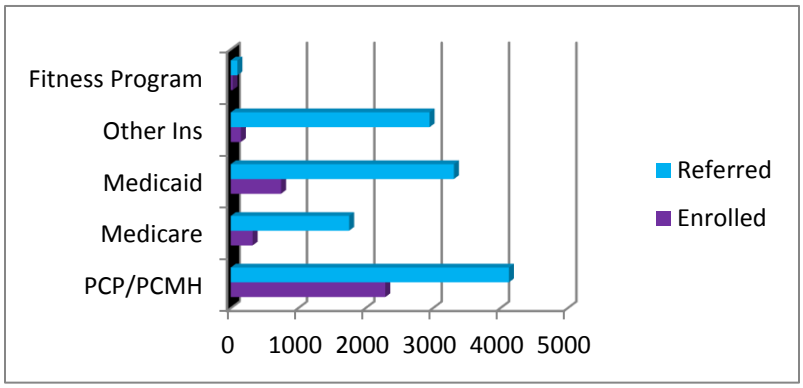
Interpretation Services
Collectively, the grantees provided 849 unduplicated participants with interpretation services, to prevent communication from being a barrier to obtaining appropriate health services.

Transportation Services
Transportation was provided to 167 unduplicated participants to and from medical appointments, as transportation can be yet another barrier to receiving healthcare.

Referrals
Of the 15,148 unduplicated participants CFEHDI grantees served, the following received the referral types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving that referral.

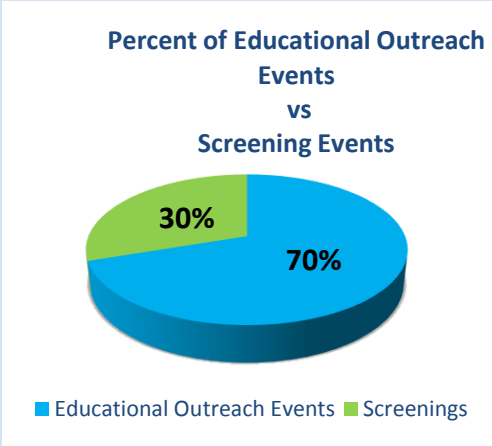
Number of Referrals

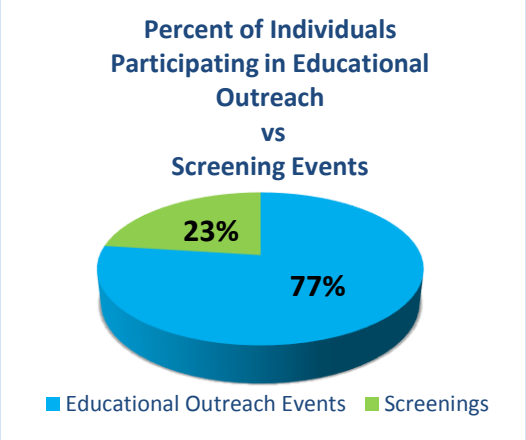
The largest number of referrals were to a primary care physician (PCP) or patient centered medical home (PCMH.) In comparison to the other programs, PCP/PCMH had the largest percentage of enrollees at 56%.



Educational Outreach and Screenings

Educational outreach and screenings allowed grantees to instill preventative health messages and make participants aware of their health status respectively. These measures were important factors in reducing health disparities, as individuals who are knowledgeable and aware of health issues tend to act. The grantees held a combined total of 178 educational outreach events with 5,865 attendees and 77 health screening events with 1,749 attendees. Thus, the grantees obtained more participants per health screening event than for each educational outreach event.





Cultural Competency of Staff

Another barrier to obtaining healthcare services is being unable to obtain care that takes your culture into consideration. Therefore, to ensure participants were receiving culturally competent care, grantees could schedule cultural competency trainings provided by NC OMHHD. A total of 21 administrative staff person, 3 medical providers, 14 nurses and 3 other medical staff person received this training.

Individual Grantee Efforts
Below are summaries of each grantees efforts to reduce health disparities by means of providing evidence-based programming, referrals, faith based outreach, interpretation services, transportation services, educational outreach, screenings, and culturally competent care.

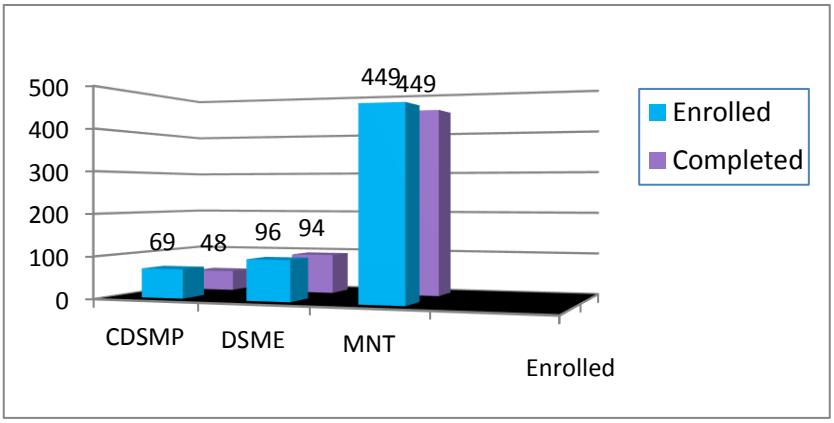
AccessCare

Evidence-Based Programs
Teaching participants to manage their health conditions by means of evidence-based programs were a key requirement of CFEHDI. In the table below you can see which evidenced-based programs AccessCare provided and the number provided.

Program	Number Provided
CDSMP	1
DSME	5
Other: MNT	449

Overall AccessCare had 614 participants complete their evidence-based programs. As you can see in the graph below, 98% (94 unduplicated participants) of the DSME participants (n=96) completed the program. Almost 70% (48 unduplicated participants) of the CDSMP participants (n=69) completed the program. All MNT participants (n=449) completed their session.

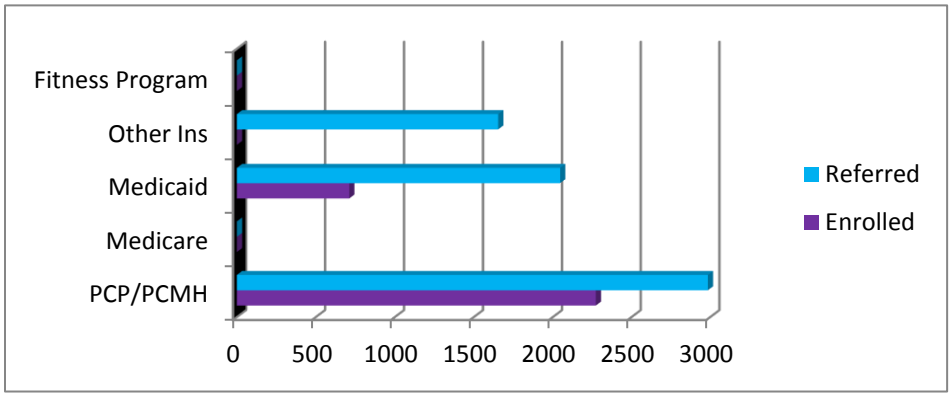
Participant Enrollment vs. Completion



Referrals
Of the 2985 unduplicated participants AccessCare has served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.

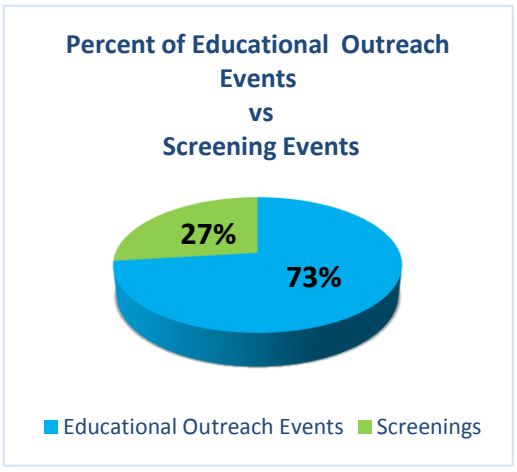
Number of Referrals

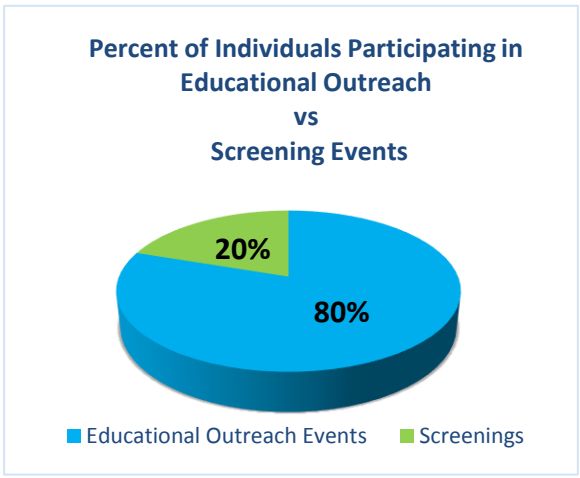
All 2985 unduplicated participants served by AccessCare were referred to a PCP or PCMH and 76% (2273 unduplicated participants) have obtained a PCP or PCMH after receiving a referral. No participants were referred to Medicare. However, 2046 unduplicated participants have been referred to Medicaid and 35% (711 unduplicated participants) enrolled in Medicaid after a referral. AccessCare also referred 1654 unduplicated participants to private insurance sources, but none report obtaining such insurance.



Educational Outreach and Screenings

AccessCare held a total of 19 educational outreach events with a total of 506 attendees and 7 health screening events with a total of 125 attendees. The following is a comparison of the efforts put towards educational outreach events versus screening events.





Most of the organizations efforts were focused upon providing diabetes educational outreach. Those types of events also garnered more participants for this organization.

Cultural Competency of Staff

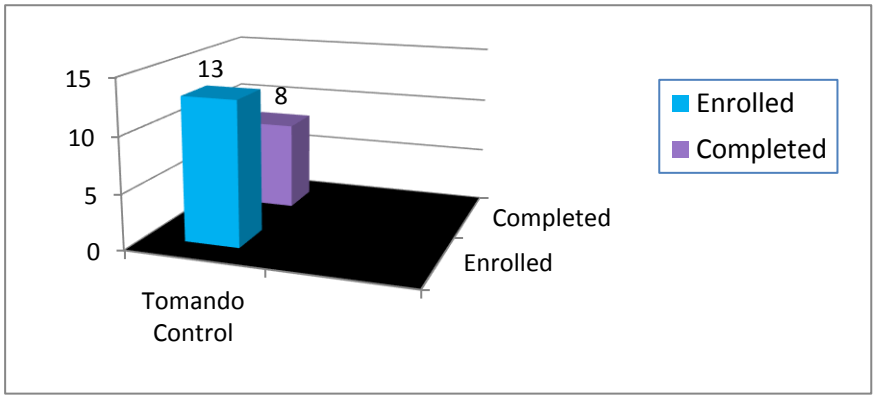
AccessCare had 5 administrative staff members receive cultural competency training.

Appalachian Regional Hospital Center (ARHC)

Evidence-Based Programs

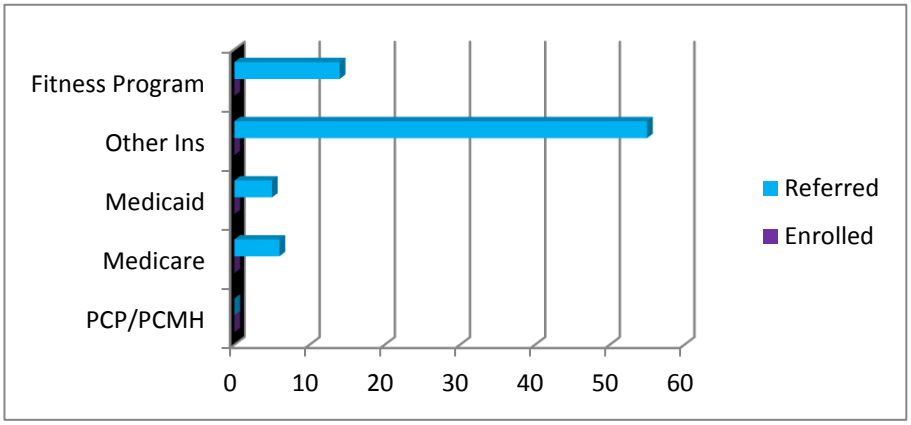
ARHC was only able to provide one *Tomando Control de su Salud* program. The organization reported that they had 1 lay leader, who left the organization. They were not able to hire another trained lay leader or have a new lay leader trained in a timely manner. There were 8 participants complete their evidence-based program, which was 62% of the participants that enrolled. These results are depicted in the Participation Enrollment vs. Completion chart below.

Participant Enrollment vs. Completion



Referrals

Of the 653 unduplicated participants ARHS served, the following received the referral types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.

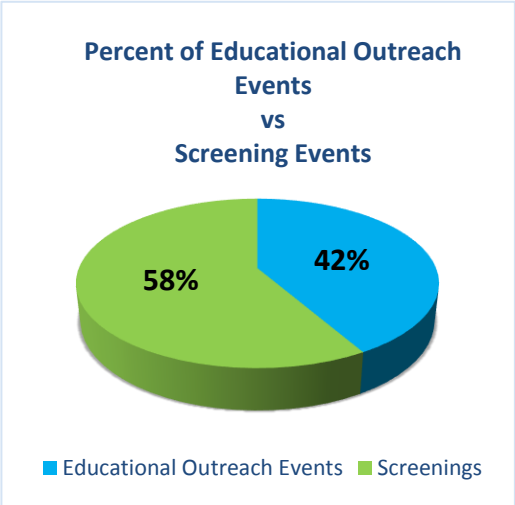


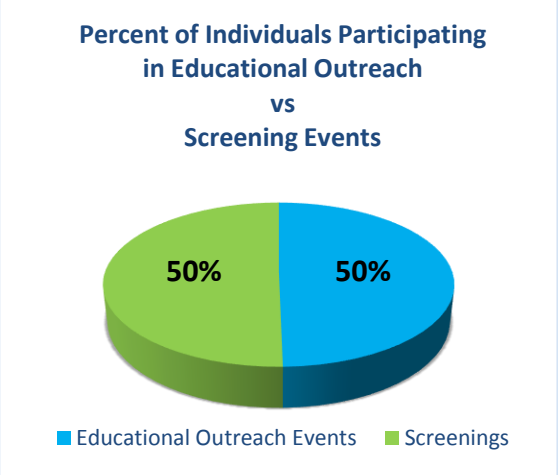
ARHS referred a total of 35 unduplicated participants to Medicare, Medicaid, and private insurance collectively. As you can see above, the target was primarily met with referrals to private insurance. No data was supplied by the grantee to indicate if participants utilized any of these referrals.

Interpretation Services
The grantee provided 641 unduplicated participants with interpretation services.

Transportation Services
Transportation was provided to 125 unduplicated participants to and from medical appointments.

Educational Outreach and Screenings
ARHS held a total of 5 educational outreach events with a combined total of 81 attendees and 3 health screening events with a combined total of 82 attendees. Thus, the organization could obtain more participants per health screening event than for each educational outreach event.



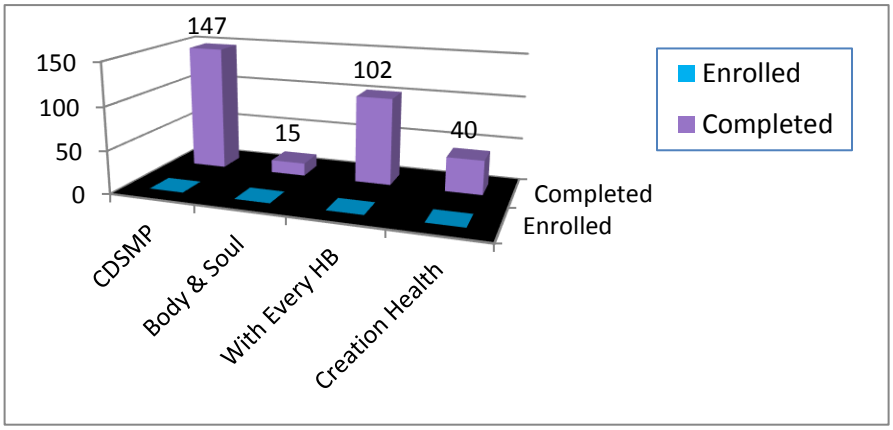


Buncombe County Health Department (BCHD)

Evidence-Based Programs
In the table and chart below you can see the extent to which BCHD met their programming goals.

Program	Number Provided
CDSMP	13
Other: Creation Health	1
Other: With Every Heartbeat is Life	0
Other: Body & Soul	2

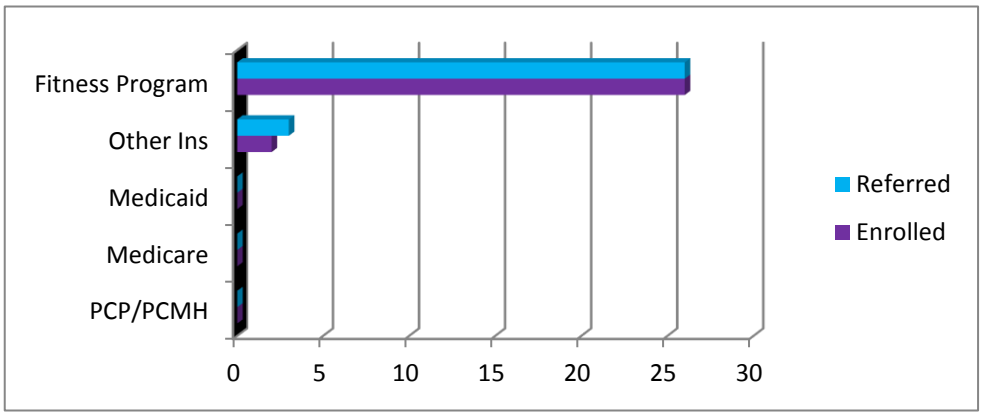
Participant Enrollment vs. Completion



Incorrect enrollment data was submitted by the grantee; therefore, it was not displayed in the table above. However, there was sufficient data to show the number of participants that completed each evidence-based program.

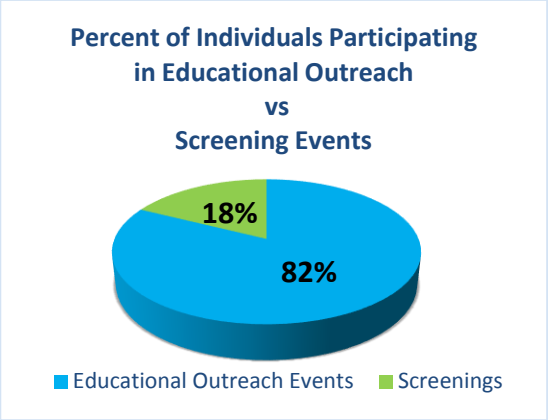
Referrals

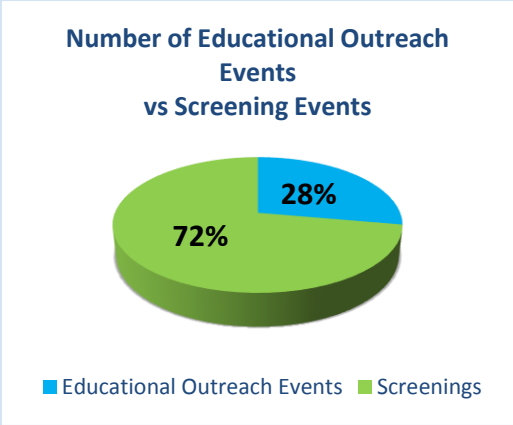
Of the 5,057 unduplicated participants BCHD has served, BCHD primarily made referrals to a fitness program and some were made to other forms of insurance. In the graph below, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.



Educational Outreach and Screenings

BCHD held a total of 5 educational outreach events with a total of 1593 attendees and 13 health screening events with a total of 340 attendees. The following is a comparison of the efforts put towards educational outreach events versus screening events.



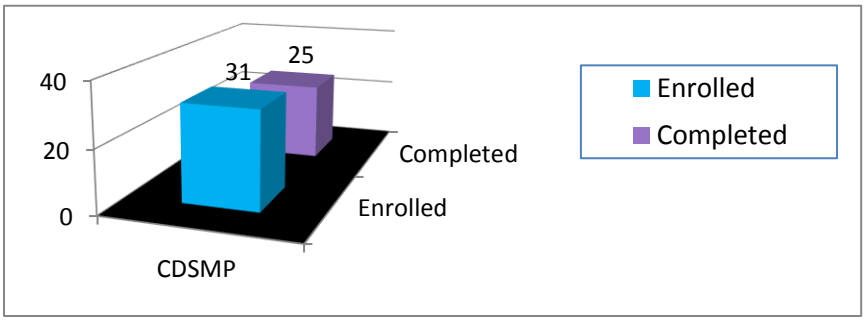


Although BCHD held far more screening events, there was far greater participation in their education outreach events.

Community Care of Southern Piedmont (CCSP)

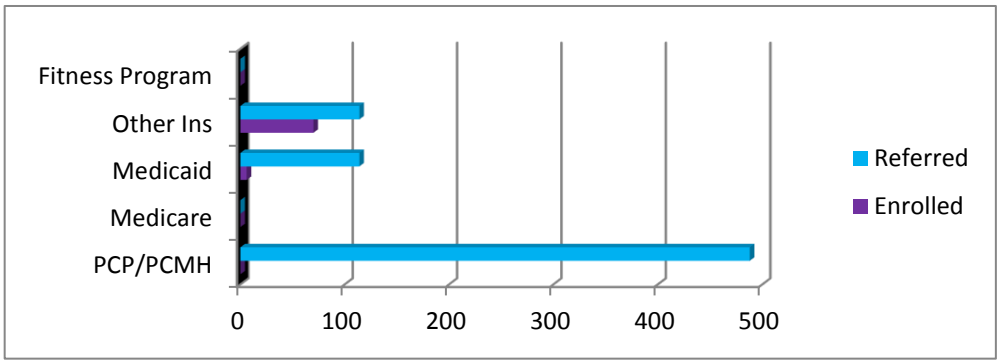
Evidence-Based Programs

CCSP provided CDSMP 4 times. Of the 31 participants that enrolled and 81% (25 unduplicated participants) completed the program.



Referrals

Of the 488 unduplicated participants CCSP has served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.



CCSP referred 488 participants to a PCMH or PCP. However, they did not provide any data to indicate if any of these participants obtained a medical home after their referral. However, 5% (6 participants) obtained Medicaid after a referral and 61% (70 participants) obtained private insurance after a referral by CCSP.

Cultural Competency of Staff

CCSP received cultural competency trainings provided by NC OMHHD. Below is a comparison of CCSP medical and administrative staff that received such training versus those who have not in the past year.

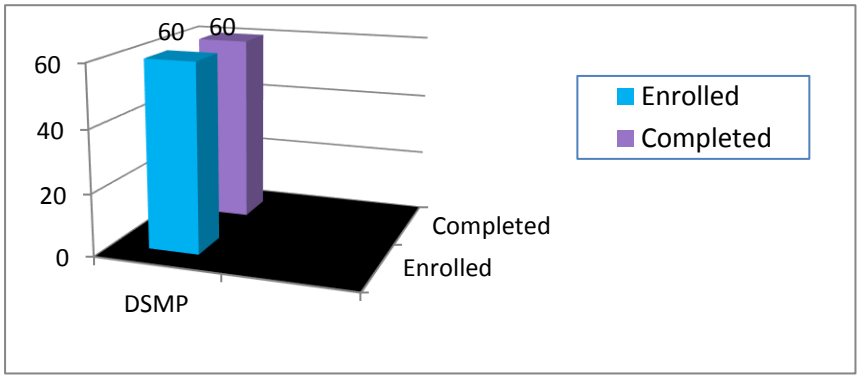
STAFF	TRAINED/UNTRAINED	%TRAINED
Providers	2:2	100%
Nurses	14:16	88%
Other Medical Personnel	3:4	75%
Administrative Staff	10:11	91%

This organization successfully ensured 88% of their entire staff received cultural competency training.

Community Health Interventions and Sickle Cell Agency (CHISCA)

Evidence-Based Programs

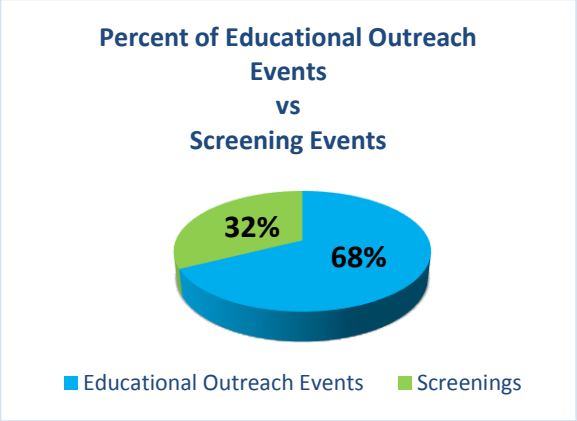
CHISCA offered DSMP to participants on 3 occasions. As you can see in the graph below, CHISCA has strong recruitment and retention rates. All CHISCA's participants completed the program in which they enrolled.

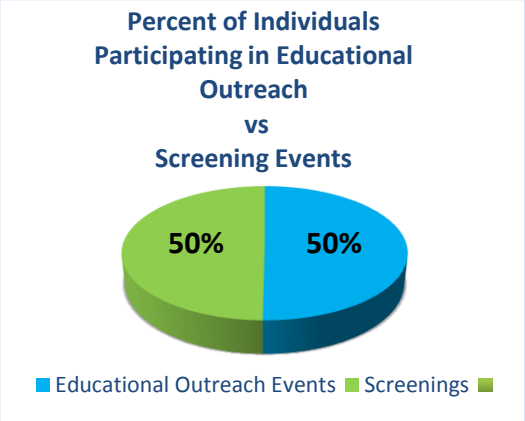


Educational Outreach and Screenings

CHISCA held a total of 25 educational outreach events with a total of 543 attendees and 12 health screening events with a total of 539 attendees.

The following is a comparison of the efforts put towards educational outreach events versus screening events by disease focus area.





Although the more than twice as much of the organizations outreach efforts were focused on educational outreach, the organization could obtain as many participants through screening events.

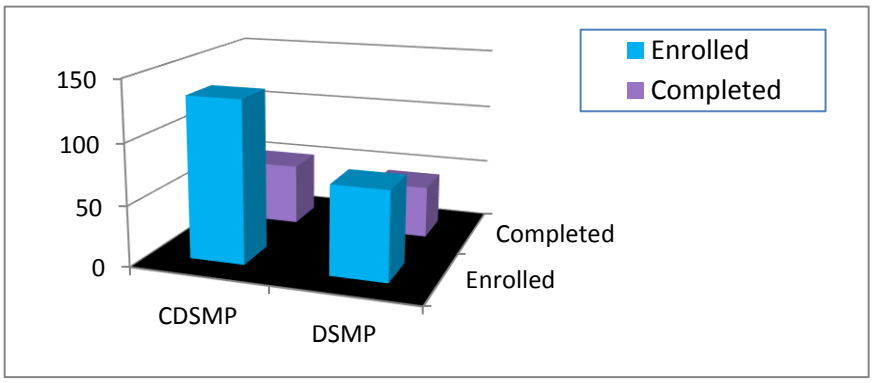
Lincoln Community Health Center

Evidence-Based Programs
LCHC providing the following type and number of evidence-based programs:

Program	Number Provided
CDSMP	10
DSMP	4
PWP	0

As you can see below, 38% of LCHC's CDSMP participants (n=133) and 59% of their DSMP participants (n=73) completed their respective evidence-based program.

Participant Enrollment vs. Completion

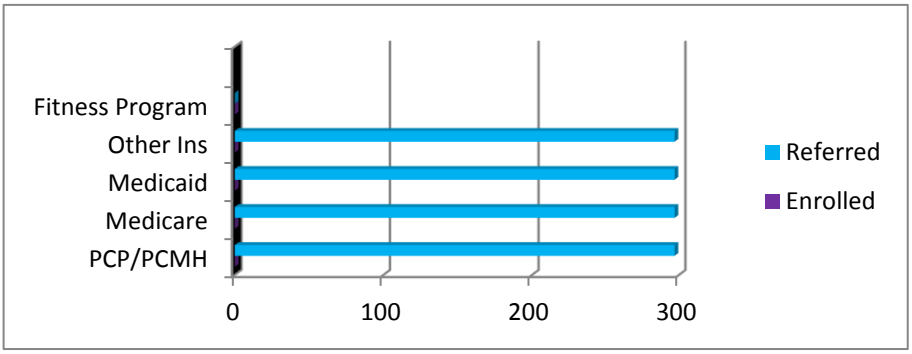


Interpretation Services
The grantee provided 141 unduplicated participants with interpretation services.

Transportation Services
Transportation was provided to 11 unduplicated participants to and from medical appointments.

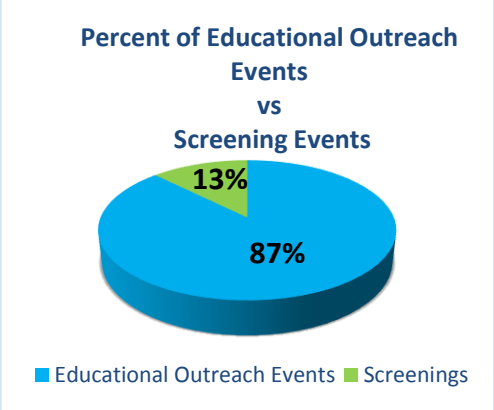
Referrals
Of the 560 unduplicated participants LCHC has served, the following received the referrals types below. In this graph, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral. LCHC reports referring 297 participants each to Medicare, Medicaid, and other types of insurance. However, they did not report if any of them obtaining any form of insurance after their referral.

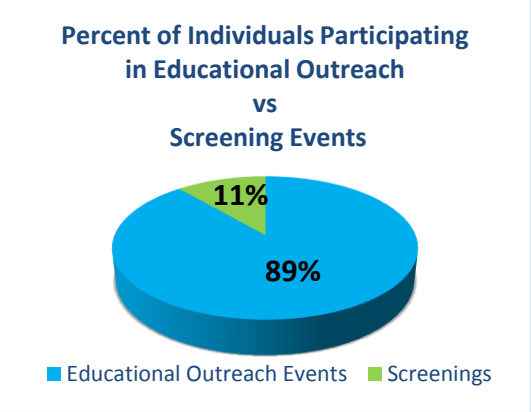
Number of Referrals



Educational Outreach and Screenings
LCHC held 7 educational outreach events with a combined total of 118 attendees and 1 health screening event with 15 attendees.

The following is a comparison of the efforts put towards educational outreach events versus screening events.



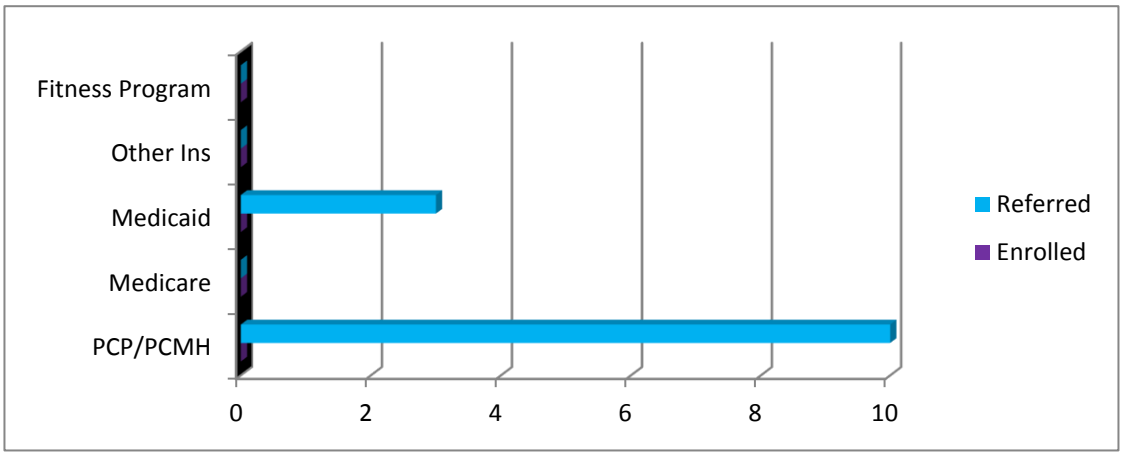


Even though most of the organizations efforts were focused upon providing educational outreach, the screening event they provided obtained as many attendees as the average educational outreach event they provided.

Lumbee Nation Tribal Programs (LNTP)

Evidence-Based Programs
LNTP provided 1 CDSMP to its participants. This grantee was not able to produce data delineating the number of participants that enrolled, completed, or gained increased knowledge from the CDSMP they offered.

Referrals
Of the 665 unduplicated participants LNTP has served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.



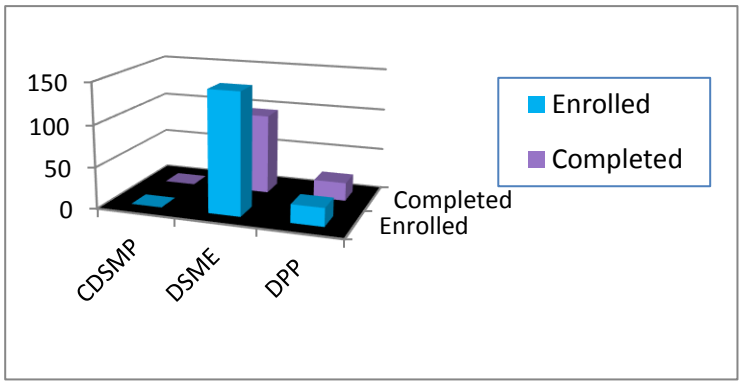
Educational Outreach and Screenings
LNTP has held a total of 4 educational outreach events with a combined total of 210 attendees. They did not hold any health screening events.

Onslow County Health Department (OCHD)

Evidence-Based Programs
OCHD provided the following programs in table below:

Program	Number Provided
DSME	8
DPP	1
Other: Power to Prevent	1

In the next graph, you will see OCHD was able to get 100% of the participants enrolled in DPP to complete that year long program. Also, 66% of the participants enrolled in DSME completed that program.



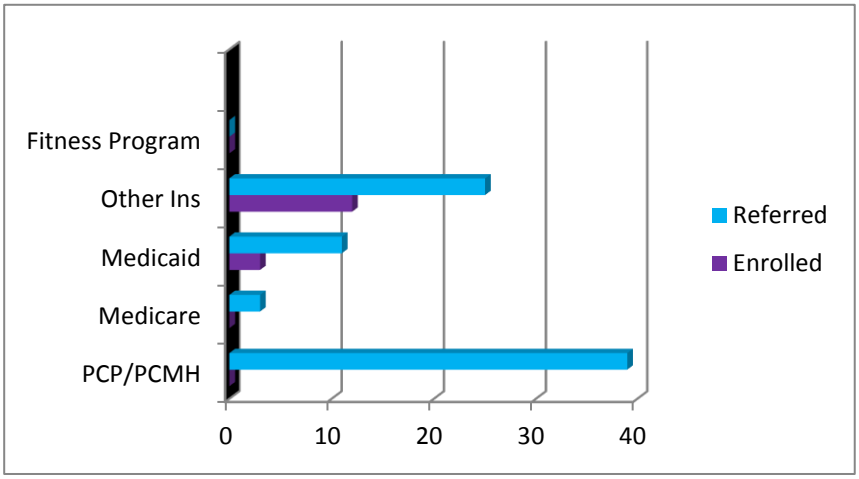
Participant Enrollment vs. Completion

Faith-Based Outreach
There was 1 pastor-led preventative health message delivered to congregation of 80 people on behalf of OCHD.

Interpretation Services
The grantee provided 25 unduplicated participants with interpretation services.

Transportation Services
Transportation was provided to 5 unduplicated participants to and from medical appointments.

Referrals
Of the 530 participants OCHD has served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.

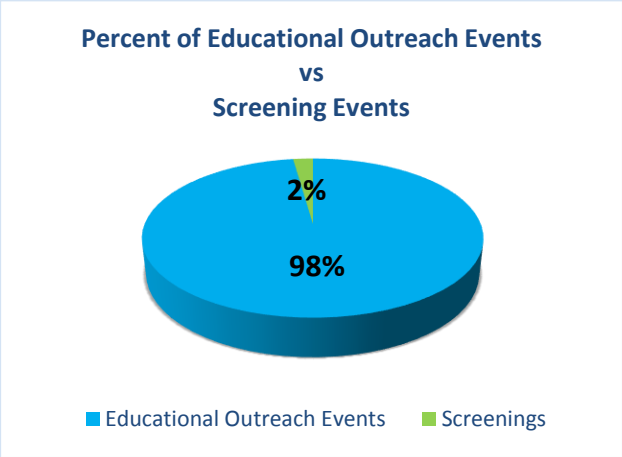


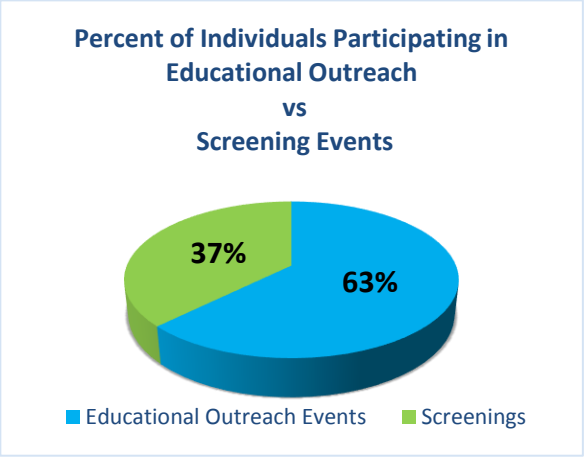
Number of Referrals

Educational Outreach and Screenings

OCHD has held a total of 88 educational outreach events with a combined total of 573 attendees and 2 health screening events with a combined total of 342 attendees.

The following is a comparison of the efforts put towards educational outreach events versus screening events.

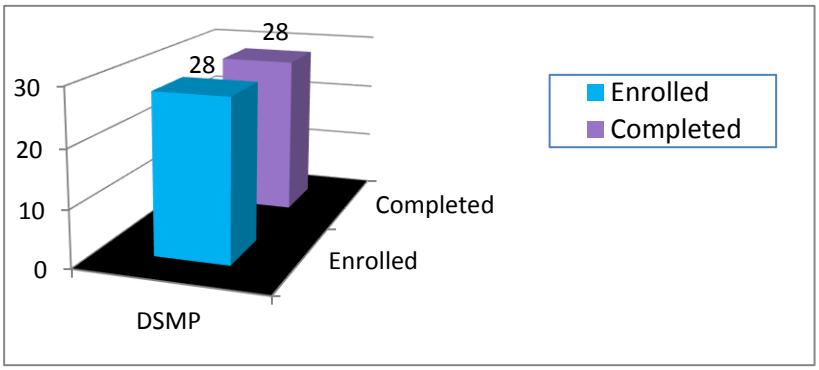




Most of the organizations efforts were focused upon providing educational outreach. OCHD obtained more participants per event when they performed screenings.

Margaret R. Pardee Memorial Hospital (MPMH)

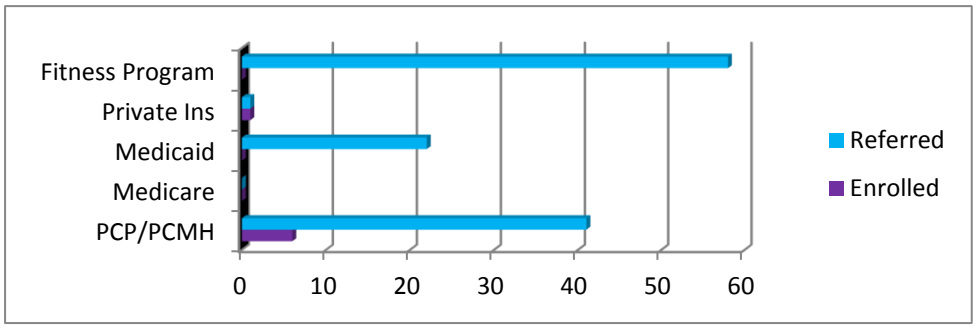
Evidence-Based Programs
MPMH provided 4 DSME programs. As you can see above, all MPMH participants completed the program they were provided.



Participant Enrollment vs. Completion

Faith-Based Outreach
There were 1 pastor-led preventative health messages delivered to congregations and 160 people who received that message.

Referrals
Of the 354 unduplicated participants MPMH served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.



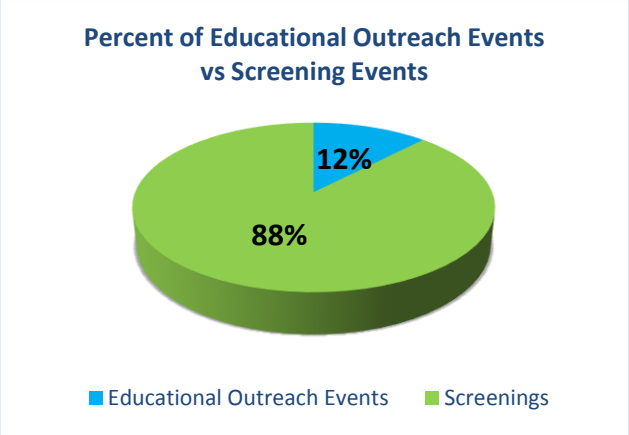
Number of Referrals

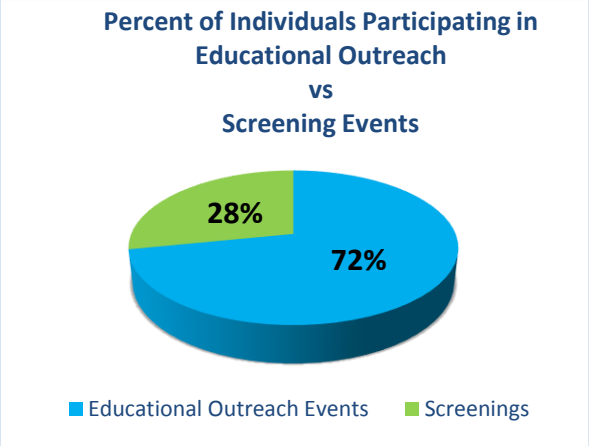
MPMH referred 12% of the participants they served to a PCP or PCMH and 2% (6 unduplicated participants) have obtained a PCP or PCMH after receiving a referral. There were 22 participants (6% of participants served by MPMHN) received referrals to Medicaid, but none of them obtained Medicaid as a result. No participants were referred to Medicare. MPMH referred

1 unduplicated participant to private insurance sources and one reported obtaining such insurance. Also, 58 unduplicated participants were provided a gym membership/scholarship, but none participants were reported as having used the scholarship.

Educational Outreach and Screenings
MPMH held a total of 5 educational outreach events with a total of 204 attendees and 36 health screening events with a total of 80 attendees.

The following is a comparison of the efforts put towards educational outreach events versus screening events.

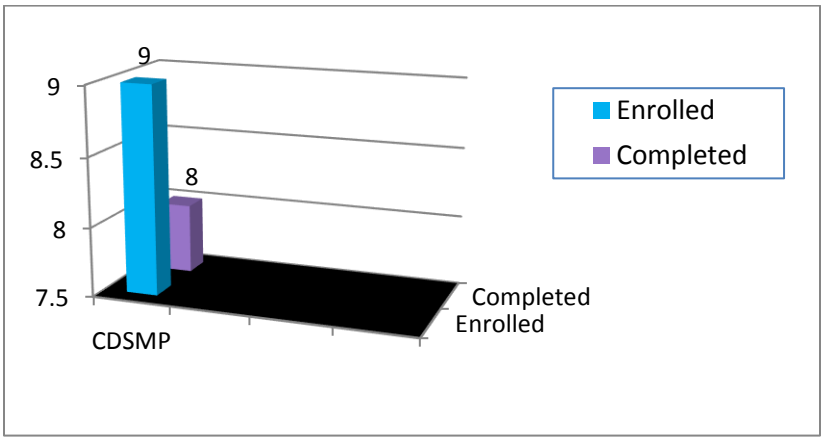




Though the organization held far more screening events than educational outreach events, they received far more participation at the educational outreach events.

Scotland Community Health Clinic (SCHC)

Evidence-Based Programs
SCHC provided CDSMP once to its participants. SCHC had 8 out of 9 participants complete their evidence-based program. Of those participants that completed CDSMP, 100% demonstrate an increase in knowledge after pre-and post-tests as graphed below.



Participant Enrollment vs. Completion

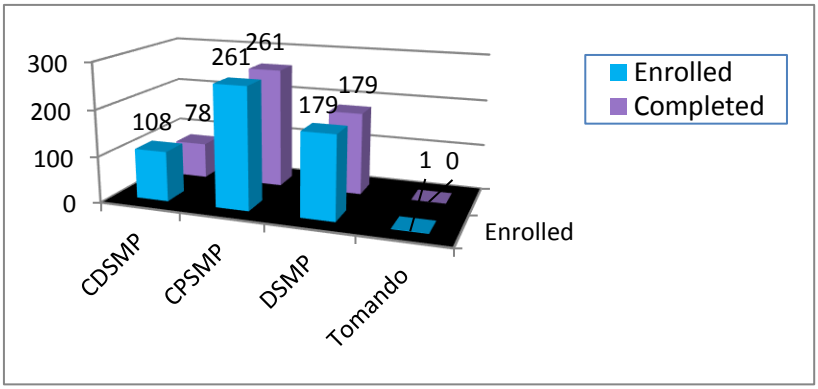
Transportation Services
Transportation was provided to 26 unduplicated participants to and from medical appointments.

Educational Outreach and Screenings
SCHC held 1 educational outreach event with 167 attendees and 1 health screening event with 51 attendees.

Cultural Competency of Staff
The grantee's staff consisted of 1 medical provider and 6 administrative staff persons, all which have received cultural competency training during the grant cycle.

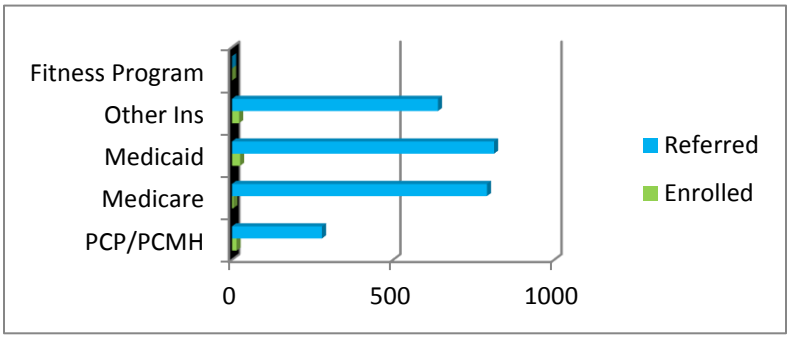
Wake County Medical Society (WCMS)

Evidence-Based Programs
This grantee provided CDSMP, CPSMP, and DSMP. As you can see below, all but 1 of WCMS's participants completed the evidence-based programs in which they were enrolled.



Participant Enrollment vs. Completion

Referrals
Of the 1088 participants WCMS has served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral. As you can see below most of WCMS's participants were referred to some form of insurance, be it Medicare, Medicaid, or other types of insurance.



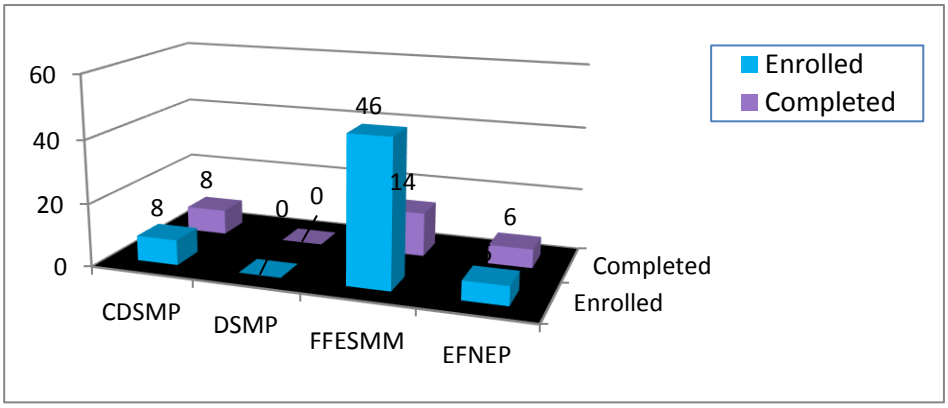
Educational Outreach and Screenings
WCMS held a total of 6 educational outreach events with a combined total of 539 attendees and no health screening events.

Wayne County Health Department (WCHD)

Evidence-Based Programs
WCHD delivered the following programs in the table below:

Program	Number Provided
CDSMP	1
DSMP	0
Other: FFESMM	24
Other: EFNEP	8

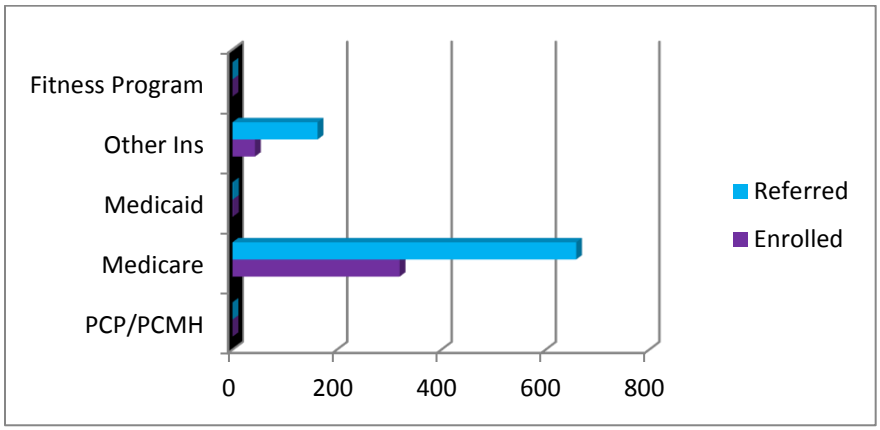
As you can see below, WCHD received the greatest amount of participation in FFESMM. Per the data provided only one participant demonstrated an increase in knowledge.



Participant Enrollment vs. Completion

Faith-Based Outreach
There have been 20 pastor-led preventative health messages delivered to congregations and 1150 people who have received these messages.

Referrals
Of the 1736 unduplicated participants WCHD served, the following received the referrals types below. In this chart, you will also see a comparison between the number of unduplicated participants referred and the number of unduplicated participants who enrolled in the referral program(s) after receiving a referral.

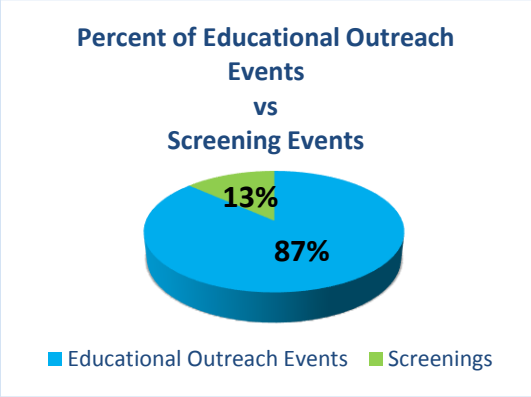


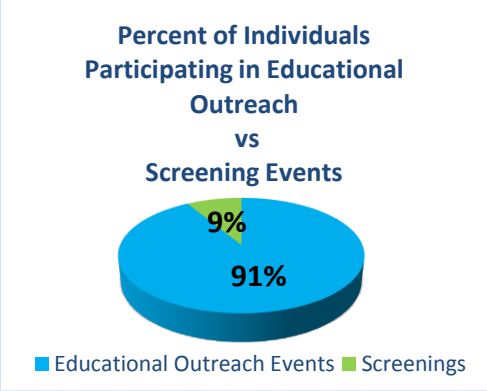
Number of Referrals

WCHD referred 659 unduplicated participants to Medicare, with 320 enrollees. Additionally, they referred 163 unduplicated participants to other forms of insurance, with 43 obtaining those other types of insurance.

Educational Outreach and Screenings

WCHD has held a total of 13 educational outreach events with a combined total of 1,331 attendees and 2 health screening events with a combined total of 175 attendees. The following is a comparison of the efforts put towards educational outreach events versus screening events by disease focus area.





Most of the organizations efforts were focused upon providing educational outreach. Those types of events also garnered more participants for this organization than for any of our other CFEDHI grantee organization.