**Proposal Narrative**

1. Organizational History and Purpose

Founded in 1910, the National Urban League (NUL) is the nation’s oldest and largest civil rights organization dedicated to empowering African Americans to enter the social and economic mainstream. With 98 affiliates in 36 states and the District of Columbia, NUL now serves 2.1 million people annually through direct services and millions more through its public policy and advocacy efforts. With its strong Board and CEO leadership, vision and infrastructure, the National Urban League is well positioned to achieve its mission to enable African Americans to secure economic self-reliance, parity, power, and civil rights.

To advance its mission, the NUL has developed a five-point social change strategy, known as the “Empowerment Agenda” that focuses work around five issue areas: Education and Youth; Economic Empowerment; Health and Quality of Life; Civic Engagement; and Civil Rights and Racial Justice. Through 100 years of civil rights leadership and social service delivery, NUL has become a recognized—and trusted—name in the African-American community.

The Urban League has a long history of providing health-related services to and advocacy on behalf of the African American community. As early as 1922, the League has been addressing issues such as infant mortality and malnutrition among African American children. During the 1980s and 90s the league focused its attention on sickle cell disease and HIV/AIDS. In 2003 the National Urban League received a three-year grant from the Centers for Disease Control to implement a diabetes education program. Most recently, the League was involved in a health and wellness education program for African American women. This women’s project, entitled “Remarkable Woman: That’s You,” funded by a $1,500,000 grant from Eli Lilly, has been implemented in four affiliates.

Through a grant from the Robert Wood Johnson Foundation, the NUL conducted an extensive study of the environmental causes of childhood obesity in Ward 8 of the District of Columbia. Findings from the project generated considerable local and national attention. Working with our local affiliate and consultants, we developed an integrated community-based approach to evaluate the usability, quality, and access of healthy food and physical exercise options in Ward 8. In 2009, Pfizer awarded a $1,000,000, two-year grant to expand its research study on the *Save our Sons* Project, a men’s health initiative that targets diabetes and obesity prevention in African American men and helps link them to a medical home and community resources to help these men adapt a healthier lifestyle.

1. Statement of Need

The proposed project targets African American adults and children who are at risk for obesity, diabetes, heart disease and other chronic health issues. In nearly all measures of health, African Americans lag behind their white counterparts. For example, African American males have significantly lower life expectancy: 66.1 years compared to the national average of 73.6 years for all men. Death rates from all causes for elders 65-74 and 75-84 are higher among Black elders than any of the other racial and ethnic groups. Forty five percent of non-Hispanic Black adults are obese. African American women have age-adjusted obesity rates of 48.8%, the third highest subgroup rate in the country.

African Americans suffer disproportionately from the effects of chronic disease more than any other group. African Americans are twice as likely to die from diabetes and 30% more likely to die from cancer or heart disease than whites. In the United States, hypertension affects about 23% of the general population and 32% of African Americans. Diabetes affects about 6% of the general population, but more than 11 % of African Americans. The prevalence of hypertension is two- to-three fold higher in diabetic compared with non-diabetic populations.

1. Program Description

In an effort to address the significant racial disparities in health, the National Urban League (NUL) seeks to expand its Community Health Worker programs to serve a total of 350 participants in two affiliate sites in Ohio and South Carolina to promote healthy lifestyles among African Americans and improve their access to healthcare and other community assets. The program will provide health education; assist clients in understanding and accessing available healthcare, social services, and insurance; offer peer counseling and support for healthy behavioral change; and advocate to ensure that clients receive needed services.

Goal 1: Promote healthy lifestyles and outcomes for underserved African Americans through education and prevention strategies.

Objectives:

* Utilize Community Health Workers to provide education about health and wellness and offer motivational, emotional, and peer support to individuals to help them identify, initiate and sustain behavioral changes that promote healthy decision-making.
* Offer engaging workshops and effective curricula to teach skills to clients to better manage their health on a daily basis.
* Focus on preventive health care, using proper nutritional diets and exercise to combat obesity, diabetes, and other chronic conditions.
* Employ Community Health Workers to help participants stay on track with their individualized health plans.
* Collect medical screening and weight loss data for program participants to evaluate outcomes.

Goal 2: Improve African Americans’ access to and utilization of healthcare services and other community resources.

Objectives:

* Help all participants find a medical home, including a primary care physician, and health insurance coverage.
* Assist participants in utilizing health assets, navigating complex healthcare systems, and tapping into the benefits of community resources such as gyms, recreational facilities, libraries, churches, health clinics, hospitals, farmer’s markets, grocery stores, healthy restaurants, etc.
* Connect participants with social services to meet their individual needs.

Through the Community Health Worker initiative, we seek to achieve the following major objectives:

* To recruit and train peer community health workers (CHWs);
* To improve health indicators: lower weight, lower blood pressure, lower glucose levels, increase of fresh fruit in diet, lower intake of salty and fatty foods, and increase in frequency and rigor of physical exercise;
* To increase participant’s healthy eating habits;
* To increase participant’s frequency of engagement in exercise ;
* To connect participant’s with healthcare providers and other community supports;
* To provide education and discussion on health issues affecting African Americans;
* To use cultural and gender appropriate materials for African Americans;
* To convene small group sessions to discuss cultural and gender-related barriers;
* To teach healthy eating and active living as key strategies for reducing one’s risk for obesity and diabetes;
* To impart skills to help empower clients to take active role in managing their own chronic illnesses;
* To enhance participants’ skills in managing pain and stress; and
* To emphasize the importance of health care provider’s involvement in achieving a healthier lifestyle.

Description of Methodology

The National Urban has established a signature program, the Community Health Worker Program, aligned with its core strategic vision and ongoing work around improving the health and quality of life in urban communities. Our Community Health Worker Program recruits and trains health educators/guides/navigators at Urban League affiliate sites in order to improve the client’s knowledge of health issues and access to health providers and community resources. It offers services in a convenient neighborhood location that is always easy to access.

The strength of our CHW program lies in its ability to influence and engage positively our participants, many of whom are current or former clients of the Urban League affiliate and have benefitted from its direct services. Our affiliates are rooted firmly in the community and have earned the trust and respect of community members. Our CHWs are African Americans (peers) from the community who offer culturally competent and relevant health education and materials targeted specifically for African Americans.

In addition, the Urban League affiliates are able to offer participants more than health care education and services. They are able to provide a wide range of wrap-around, one-stop shop services such as job training and placement, housing counseling, financial education, seniors programs, substance abuse and prevention programs, and voter mobilization. By helping our participants address a broad range of economic, social and psychosocial issues, we stabilize and improve the quality of their lives and incorporate a holistic approach to health.

Through our partnership with Morehouse School of Medicine, we have developed an adaptive and responsive curriculum that builds upon the experience of the Urban League movement. The curriculum has been adapted from the CDC’s *Power to Prevent* curriculum and reflects information learned through community needs assessments, focus group data from target population, and information collected and assessed by affiliate professional staff. Based on our experience, we have included a strong mental health and wellness component that acknowledges the stress factors of race and poverty in underserved communities.

Through a long, rich history of serving African American community members, the NUL affiliates and Morehouse developed an authentic, culturally- sensitive curriculum that provides educational awareness for chronic disease management and community resources, but also forces participants to take ownership of their health, lifestyle behaviors and health treatment. We have also developed an Implementation Guide (provides a step-by-step framework for implementation activities); Community Health Worker Training Curriculum and an Evaluation Manual.

At each site the current staff and CHWs will recruit additional participants. In Lorain County, Ohio, we will recruit and serve an additional 70 men for a total of 195 men in year one, and an additional 140 men for a total of 265 in year two. In Columbia, South Carolina we will recruit and serve an additional 55 families in year one for total of 155 families, and an additional 110 in year two for a total of 210. These two programs have been operating successfully. With grant support, we will expand direct services, enhance our local nonprofit partnerships, and strengthen these communities.

Action Plan, Workshops, Medical Screenings

Together, the CHW and the client will develop specific goals for the client to achieve and a Six Month Action Plan for achieving those goals. The CHW will provide clients with educational materials and resources and assess which community assets (such as nutrition programs, cooking classes, etc.) are appropriate to their needs. The CHW and the client will develop a pledge to work towards initiating behavioral changes and achieving the desired goals.

CHWs will use curricula to help move clients along a path to better health behaviors and outcomes. This training process will take between six and eight months to complete. The time frame for completing the program will depend on a group’s ability to master concepts, engage in activities and overcome barriers, which may range from bad eating habits to low-literacy levels.

The CHW will meet again with participants at the three-month interval to assess progress and ensure that utilized assets are meeting expectations. Our goal is for clients to remain in the program for at least six months so that we can evaluate their progress at least twice during the program: once at the three-month period and then again at the six-month period. However, we recognize that some groups will need more than six months to demonstrate successful health outcomes. In this case, the program may be extended up to another six months.

At the end of six months clients will be asked to complete a post-intervention CDC BRFSS questionnaire and the CDC Health-Related Quality-of-Life 14-Item Measure. The CHW will meet with each client to review and document their progress toward attaining each goal in their Action Plan. The following health indicators are expected from each individual who completes the program: lower weight, lower blood pressure, lower glucose levels, increase of fresh fruit in diet, lower intake of salty and fatty foods, and increase in frequency and rigor of physical exercise.

Each client who completes the program will receive a participation incentive (such as a gift card, sweatshirt, or exercise equipment) to thank and compensate them for their participation and commitment.

Additionally, other CHWs will:

* Assist participants with doctor visits and help them find a medical home;
* Supervise follow-up visits by participants to their medical appointments.
* Identify and recruit clients per site to receive comprehensive services provided at the affiliate site;
* To follow and support participants receiving such services, often providing motivational and peer guidance;
* To assist participants in accessing a variety of community health assets and resources;
* To provide basic, informal health education to participants.

Training

Staff from the NUL and several affiliates have received three years of training from the Morehouse School of Medicine and are well prepared to conduct trainings. The NUL and the local affiliate CHWs will set up and facilitate a mandatory three-day training (other trainings as scheduled) on how to conduct program activities, policies and procedures for supervision and action plans.

A myriad of training approaches will be used in order to maximize the knowledge that can be gained by trainees. CHWs training will be based on community-specific culture and program-specific materials and procedures. Instructional methods during the training may include: informational lecture, role play, didactic interactions, interactive discussion, experiential processing, creative application of intervention materials, and small work groups.

CHWs will also receive follow-up training by the Urban League affiliate in the following areas: roles and responsibilities of CHWs; scope of the health disparities in African American communities; the importance of healthy eating, ways to motivate or influence positive health living behaviors, regular physical activity and visiting the doctor; and ways that children and families can increase their physical activity and eat healthier. Materials from the CDC “Road to Health” Toolkit will be used for this aspect of training.

1. **Evaluation**

The program’s success will be determined if the below outcomes are achieved at the designated intervals in the program:

1. An 85% retention rate of total program participants that enroll in the program.
2. 85% of participants will show an increase in their knowledge of the curriculum by at minimum of 50% during the program.
3. 30% of participants who have not seen a doctor or dentist in more than one year will visit the doctor or dentist at the first 3-month interval.
4. 30% of participants will have at least one visit with a health professional (can be non-medical) at the first and second 3-month interval.
5. 30% of participants will realize a 7% weight loss goal.
6. 30% of participants will increase their self-reported baseline exercise level by 50%.
7. 85% of participants will complete pre- and post surveys and 30% will report a decline in personal barriers that prevented them from seeking health care.

These specific, anticipated key outcomes are based on our past experience and the actual outstanding outcomes achieved with our other CHW programs. Currently, we operate CHW programs in five catchment areas: Dallas, Texas; Lorain County, Ohio; Buffalo, New York; St. Louis, Missouri; and Columbia, South Carolina.

Our experience with previous evaluations indicates remarkable results. For example, in one program we had established a goal of serving 25 participants, but recruited and served 44 participants. The retention rate for participants was 93.2% and exceeded our expected goal of 80%. In our pre-test and post-test questionnaire to measure improvement in knowledge base among program participants, we had nearly 50% of participants who received post test scores of 100. We saw 98% of participants who exceeded goal of exercising 150 minutes per week; decreases in hypertension by 23%; and increased health insurance enrollment by more than 58%.

When evaluating our program we will use at least four stages: Formative Evaluation is the process of testing program plans, messages, materials strategies for weaknesses before they are put into place. Process Monitoring and Process Evaluation, mechanisms for determining whether the strategies for reaching the target population is working as expected and the intervention is being implemented as planned. Outcome Monitoring is the tracking of changes in knowledge, skills, behaviors, attitudes, beliefs, ands or intentions of the participants participating in the intervention. Outcome Evaluation, measures whether the intervention had an effect on the behaviors, attitudes skills, interventions, and beliefs of the individuals who participated in the intervention.

1. **Conclusion**

With support from the XYZ Foundations, the NUL will expand its successful CHW programs in Ohio and South Carolina, and serve an additional 250 participants during the grant period. The program will help improve the overall health of African Americans and address issues such as obesity, diabetes, hypertension, high cholesterol and chronic disease. Also, the program will connect participants to health insurance, a medical home, and social services to ensure long-term positive health outcomes.