CEDAR RIVERSIDE PEOPLE'S CENTER CLINICS & SERVICES

People's Center
CLINICS & SERVICES

Project HEART

CONTEXT

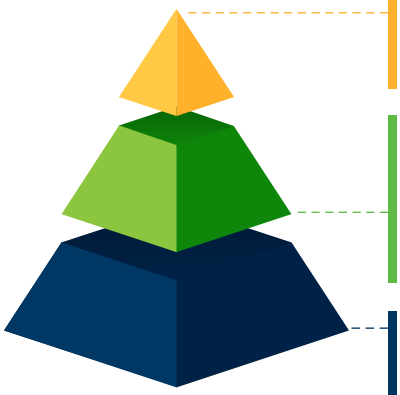
Goal: People's Center Clinics & Services aims to reduce disparities in diabetes and hypertension outcomes for individuals of African and African American descent in neighborhoods throughout South Minneapolis.

Causes: Cultural and systemic barriers led to disparities in education, employment, income/wealth, housing, neighborhood conditions, access to health care, transportation, social connections and support that directly affect health.

Population: Approximately 76,500 individuals of African and African American descent live in Minneapolis.

Issue: Diabetes and cardiovascular disease continue to be among the top 10 causes of death, premature death, morbidity, and the highest contributors to unnecessary healthcare costs. Additionally, there is a large disparity in health outcomes of diabetes and hypertension between African and African American populations when compared to their white counterparts.

APPROACH



Providing community education and activities, including faith-based workshops, nutrition classes co-led by community partners, exercise classes, and fresh produce distribution in addition to culturally responsive clinic services.

Redesigning delivery of care—adding Certified Diabetes Educator, Clinical Pharmacist, and bilingual Community Health Worker —to enhance care coordination efforts and better manage chronic conditions with patients while building stronger relationships with community partners and members.

Addressing barriers to health such as access to care, transportation, limited or no access to fresh produce, and no space to exercise using information gathered from our community.

ROOT CAUSES/ CONDITIONS FOR HEALTH

Addresses the social and economic conditions for health (also known as the social determinants of health). This often happens by changing local, regional or state policy, changing the way systems work or changing the environment.

ORGANIZATIONAL/ INSTITUTIONAL CHANGE

Addresses a health area by changing policies or systems in a school, clinic, hospital, etc. to support healthy behaviors and individual risk/ protective factors.

HEALTH PROMOTION/ DIRECT SERVICE

Addresses individual or family-level risk/protective factors through health education, programming, case management, etc.

"I had seen diabetes specialist before and it never went anywhere. But I saw Kelly, and she said 'I hope you have an open mind, because I'm going to change your life.' And true enough, she did." – program participant

IMPACT

- Provided enhanced care coordination to 273 patients with uncontrolled hypertension and 150 patients with uncontrolled diabetes
- 59% of patients with uncontrolled diabetes made significant improvements in their diabetes management
- Racial disparities gap for diabetes decreased from 10% in 2017 to 3% in 2018
- Racial disparities gap for hypertension decreased from 7% in 2017 to 4% in 2018

37%
of uncontrolled hypertension patients now under control

38%
of uncontrolled diabetes patients now under control

DEPARTMENT OF HEALTH
CENTER FOR HEALTH EQUITY

CEDAR RIVERSIDE PEOPLE'S CENTER CLINICS & SERVICES

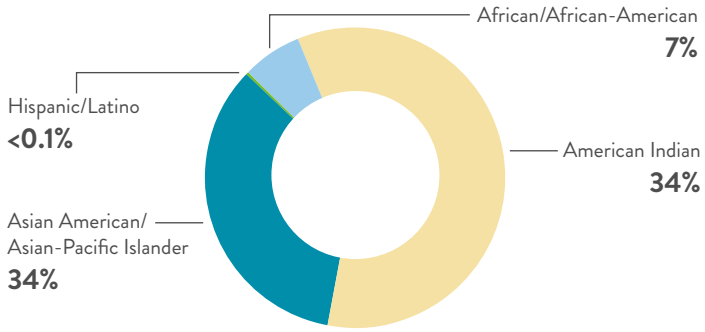
People's Center
CLINICS & SERVICES

People's Center Clinics & Services offers culturally responsive medical, dental, and behavioral health care and supportive services. All patients are welcome, regardless of their ability to pay for care. Our mission is to deliver affordable health care, inspire hope, and promote community wellness. Our vision is to improve lives, transform communities, and achieve health equity for all.

PRIORITY HEALTH AREA SPOTLIGHT

Diabetes is the sixth leading cause of death in Minnesota and is the leading cause of kidney failure, lower-limb amputations, and blindness. One in four Minnesotans have pre-diabetes, including 92,000 children. Rates of pregnancies complicated by diabetes are increasing fastest among Hispanic/Latinx, American Indians, and Asian Americans (groups that tend to receive less than adequate prenatal care). A lack of culturally and linguistically appropriate diabetes education materials and support systems contribute to disparities in the management of diabetes complications and diabetes related-deaths. Socioeconomic disparities and a lack of culturally diverse or competent health care providers also contribute to barriers for effective diabetes management for people of color and American Indians.

Collective Impact: 31,347 individuals were reached through the work of five grantees addressing this priority health area in 2017-18. The proportions of individuals reached by race/ethnicity are shown in the figure below.



EHDI grantees addressing diabetes identified common measures to track and report. Collective results include:

- ★ 1,039 diabetes screenings
- ★ 1,246 participants in diabetes prevention or management programs
- ↑ Higher amounts of weekly physical activity among participants compared to before programming

MDH ELIMINATING HEALTH DISPARITIES INITIATIVE

The Eliminating Health Disparities Initiative (EHDI) grant program was created to address health inequities for populations of color and American Indians across eight different priority health areas. Since 2001, the EHDI approach has been to support organizations and projects run by and for communities of color and American Indians to develop and implement strategies that are effective in reaching their communities. Every few years, the program reallocates the competitive grants to organizations and tribes across the state of Minnesota. The current grant cycle is from 2016-2019.