Organizational Capacity

1. What is your organization's mission? (100 words)

The American Diabetes Association (ADA) is a 501(c)(3) nonprofit corporation founded in 1940 with the mission to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The Mission Delivery and Community Outreach Department of the ADA office in Raleigh, North Carolina, aims to fulfill this mission, but with a special focus on preventing diabetes among high-risk groups in eastern North Carolina, where more than 75% of the counties are classified as tier one or tier two.

2. What have you achieved in the past year to advance your mission and improve your organization's capacity? (300 words)

Over the past year, we advanced our mission by providing financial support for diabetes research projects and by implementing community-based programs. Since 2005, the ADA has given more than 6.1 million dollars to diabetes researchers in the Triangle area. Over the past year, our office brought two ADA programs, Live Empowered and Family Link, to eastern North Carolina.

Live Empowered is one of several ADA programs targeting minority populations. In 2012, 16 churches and about 1,500 individuals in eastern North Carolina participated in ID Day, which is a component of Live Empowered designed to raise diabetes awareness in African American churches. We are currently recruiting churches to participate in Live Empowered workshops. At present, four churches have committed to participate.

During the past year, our office brought Family Link to eastern North Carolina. A kick-off event was held in November and provided an opportunity for families with children who have diabetes to participate in disease management information sessions and network with other families. Post-event survey results found majority of families reported increased disease management knowledge and connecting with at least one other family.

In summer of 2013, our office served 180 children with diabetes through Camp Carolina Trails in King, North Carolina. Post-camp survey results showed a majority of responders reported improved ability to manage their diabetes and stronger perceived peer support.

In order to continue to improve and expand our outreach efforts, we worked over the past few years to increase our organizational capacity. Fundraising totals for our office have increased from about 500,000 dollars in 2010 to almost one million dollars in 2012. In the last three years, our staff size increased from 4 ½ to 6 fulltime employees. With these added staff members, we have been able to implement new programs and provide more community support.

Your Participants

3. What issue are you addressing? How many individuals or groups within your focus area are affected by it? (300 words)

Diabetes is a serious health condition that negatively impacts the lives of those affected. Diabetes prevalence has increased in the US and disproportionately so among some minority groups. The incidence of newly diagnosed cases of diabetes in the US almost tripled from 1990 to 2010 (1). In North Carolina, the prevalence of diabetes is now 10.4% (2). In Wilson County, the prevalence of diabetes is higher at 13.8% (3), which places it in the top 20% of North Carolina counties in terms of diabetes prevalence (4). About 11,300 individuals in Wilson County report having been diagnosed with diabetes (4).

African Americans are affected disproportionately by diabetes. Compared to non-Hispanic whites, risk of being diagnosed with diabetes is 77% higher among African Americans (5). Prevalence of diabetes among African Americans in North Carolina is 14.1% (2), and diabetes is the fourth most common cause of death among this minority group (5).

In general, risk of diabetes increases with age. It is estimated that only 0.3% of youth (<20 years old) have diabetes (5), but that youth aged 10 to 19 years have higher incidence of diagnosed diabetes than younger children. The highest disease incidence rates among youth are found in minority populations (5). In North Carolina, the percentage of African Americans reporting ever having been diagnosed with diabetes continues to increase with age and peaks at 36.3% of those aged 65 to 74 years (2).

Diabetes is a serious problem across our state, but disease prevalence is higher in Wilson County than in most other counties in North Carolina. Diabetes disproportionately affects African Americans, and disease prevalence increases with age. Diabetes often leads to serious health complications, which can impact a person's family life, career, and overall quality of life.

Question 3: References

1. Diabetes report card for 2012. Retrieved November 4, 2013, from the Centers for Disease Control and Prevention website: http://www.cdc.gov/diabetes/pubs/pdf/diabetesreportcard.pdf

2. 2012 BRFSS survey results: North Carolina: diabetes among African Americans. (2013). Retrieved November 4, 2013, from the N.C. State Center for Health Statistics website: http://www.schs.state.nc.us/schs/brfss/2012/nc/afam/DIABETE3.html

3. Diabetes interactive atlases: Diagnosed diabetes percentage in Wilson County. (2010). Retrieved November 29, 2013, from the Centers for Disease Control and Prevention website: http://www.cdc.gov/diabetes/atlas/countydata/atlas.html

4. State & county quick facts: Wilson County, North Carolina. (June 27, 2013). Retrieved November 29, 2013, from United States Census Bureau website: http://quickfacts.census.gov/qfd/states/37/37155.html

5. 2011 National diabetes fact sheet. (May 23, 2011). Retrieved November 4, 2013, from Centers for Disease Control and Prevention website: http://www.cdc.gov/diabetes/pubs/estimates11.htm#3

4. Describe the participants who will be included in your program. How many are financially needy? Are the participants different in any way from the full population you described in question three? (200 words)

Our program will be implemented in eight African American churches in Wilson County, North Carolina, targeting approximately 400 African American children and their caregivers. We estimate our program will reach more than 200 families and 1,200 individuals.

We expect financial need of our participants to be higher than in Wilson County overall. The U.S. Census Bureau estimates 21.9% of persons in Wilson County are living below the poverty line, compared to 16.1% in North Carolina overall (1). Prevalence of poverty

among children in this county is 36% (2), and 67.1% of children attending public schools in Wilson County applied for free and reduced lunch in 2012 (3). We will recruit churches in school districts where more than 75% of children applied for free and reduced lunch in 2012. Seven schools meet this criterion (3).

We expect rates of obesity and physical inactivity among our participants to be at least as high as in Wilson County overall. Thirty-two percent of adults in Wilson County are obese, compared to 29% in North Carolina overall (2). Thirty-two percent of adults in Wilson County are classified as physically inactive (2), and majority of youth are not getting recommended amount of daily exercise (4).

Question 4: References

1. State & county quick facts: Wilson County, North Carolina. (2013, June 27). Retrieved November 29, 2013, from the United States Census Bureau website: http://quickfacts.census.gov/qfd/states/37/37195.html

2. Wilson County, North Carolina, health outcomes. (2013). Retrieved November 29, 2013, from County Health Rankings & Roadmaps: A Healthier Nation, County by County website: http://www.countyhealthrankings.org/app/north-carolina/2013/wilson/county/outcomes/overall/snapshot/by-rank

3. Free & reduced meals application data. (2012). Retrieved November 29, 2013, from Public Schools of North Carolina: Financial & Business Services website: http://www.ncpublicschools.org/fbs/resources/data/

4. Child Health Assessment and Monitoring Program: Children's physical activity and nutrition. (2010). Retrieved November 3, 2013, from the N.C. State Center for Health Statistics website: http://www.schs.state.nc.us/schs/pdf/CHAMP_HealthBehavior_2009_WEB_081010.pdf

Your Impact

5. What impact are you committed to achieving? How many of the participants will achieve that impact? (400 words)

We plan to recruit eight African American churches in Wilson County to participate in our program. We estimate that the average number of church members who regularly attend Sunday morning service to be about 150 members per church. In total, we estimate

our program has potential to impact about 1,200 individuals, which includes about 400 children and adolescents.

The program described here is a diabetes prevention program that targets African American youth in Wilson County. Program impact goals are related to improving behaviors associated with obesity and risk of diabetes. To improve impact of our program among youth, we are also targeting caregivers with family-centered program components.

We do not anticipate any of the churches will withdraw from participation in this program. Among regular church attendees, we anticipate 70% participation in program components to occur during regularly scheduled church activities (e.g., Sunday school). These compulsory program components will impact about 280 children and about 560 adults. Based on our experience implementing health promotion programs in various community settings, we estimate 45% of caregivers will participate in all program components, indicating about 540 individuals, youth and caregivers, will experience full program impact. At present, we do not know if all program components are necessary to achieve significant impact.

Our program aims to impact health behaviors associated with obesity and diabetes risk: eating behaviors and physical activity. We anticipate short- and mid-term impact of this program will be increased consumption of fruits and vegetables by one serving per day; decreased consumption of sugar-sweetened beverages by 50%; and an average increase of 1,500 steps per day. Target impact values were based on results achieved by past interventions with similar program components and target populations. We anticipate achieving these results among children with caregivers who participate in all program components. We anticipate attenuated impact among children with caregivers who did not participate in all program components.

If the program described here is shown to be effective in changing health behaviors associated with diabetes risk, the ADA could implement this program in African American churches across North Carolina.

6. How many of the participants would be likely to achieve the anticipated impact if your program did not exist? (200 words)

Children's health behaviors frequently mirror those of their parents. Poor diet and exercise habits often lead to overweight and obesity, and weight status is positively correlated with prevalence of type two diabetes (1). In North Carolina, almost 75% of African American adults are overweight or obese (2), and their children are patterning after them with 46% of African American youth 10 to 17 years of age currently classified as overweight or obese (3). Based on this state surveillance data, we estimate that without our program, of the 400 children targeted, about 100 children would have good health behaviors and achieve normal weight status as adults. We estimate 75% of youth targeted by our program will maintain poor health behaviors learned as children and will eventually be classified as overweight or obese adults. Our program has potential to positively impact these 300 children and their caregivers through a health behavior change intervention.

Our program could impact more youth through utilization of Sunday schools in African American churches as sites for diabetes prevention programs. Sunday school has been used successfully for other health interventions, but to our knowledge has not been used to implement diabetes prevention programs.

Question 6: References

1. Nguyen, N.T., et al. (2008) Association of hypertension, diabetes, dyslipidemia, and metabolic syndrome with obesity: Findings from the National Health and Nutrition Examination Survey, 1999 to 2004. *Journal of the American College of Surgeons.* 207, 928-934.

2. Behavioral Risk Factor Surveillance System - North Carolina 2012: Overweight and obesity prevalence and trends. (2013). Retrieved November 2, 2013, from the Centers for Disease Control and Prevention website: http://apps.nccd.cdc.gov/brfss/race.asp?cat=OB&yr=2012&qkey=8261&state=NC

3. Child Health Assessment and Monitoring Program: Child's weight status in North Carolina (2009). (2010, July). Retrieved November 5, 2013, from East Smart Move More NC website: http://www.eatsmartmovemorenc.com/Data/DataReports.html

Your Program

7. Describe the work for which you seek funds. What approach will you use to achieve the anticipated impact? (500 words)

The diabetes prevention program outlined here will be implemented over an eight week time period as a supplement to Live Empowered, an existing faith-based diabetes prevention and management program sponsored by the ADA and implemented by church ambassadors. The program components for which we seek funds will strengthen this existing program by addressing issues identified by stakeholders: 1) Difficulty targeting adult church members at risk for diabetes to encourage participation in Live Empowered workshops; and 2) Lack of a strong youth component, with the exception of a one-hour workshop aimed at preventing diabetes among African American youth. To address these issues, our approach includes two key elements: 1) A program kick-off event including health screenings; and 2) Live Empowered, Youth Edition – a diabetes prevention program targeting youth through Sunday school lessons with supplemental parental involvement components.

The program kick-off event will be sponsored by the ADA in partnership with a local health clinic that will perform health screenings. Adults determined to be at risk for diabetes will be encouraged to register for Live Empowered workshops. Other services include on-site scheduling of follow-up appointments with the health clinic as needed and provision of educational materials and information about other relevant community resources.

Live Empowered, Youth Edition includes eight Sunday school lessons that integrate health information with biblical stories. Lessons will be designed by the ADA with input from stakeholders, and Sunday school teachers will deliver lessons to youth. Lessons will be fun and interactive with a focus on modeling health behaviors (e.g., role playing, video segments featuring role models). Nutrition information provided will be based on the Traffic Light Diet developed by Epstein et al. (1). Physical activity lessons will be supplemented by participation in a Step Challenge, which requires youth use a pedometer and step journal to document physical activity levels during the week.

Live Empowered, Youth Edition includes several program components to encourage family involvement: 1) Each week, during Sunday service, the health ambassador or pastor will inform congregation of health lessons being taught in Sunday school and how parents could incorporate this lesson into their family's daily routine. 2) For at least four Sundays, youth and caregivers will participate in family-based health sessions. Church leadership will determine best time to schedule these sessions. 3) For at least two Sundays, youth will prepare a healthy snack for parents after church. 4) Parents will be encouraged to participate in the Step Challenge. Each parent will be provided with a pedometer, individualized step goal, and step journal. 5) Family Night will be held at a local grocery store. A nutrition mentor from the African American community will demonstrate how participants could purchase foods based on the Traffic Light Diet model and how to prepare healthy meals on a small budget.

Program sustainability is supported by the presence of a local ADA office in Raleigh, North Carolina. The ADA is continually working to develop relationships with churches in eastern North Carolina and will continue to provide educational resources and support as needed.

Question 7: References

1. Epstein, L. H., & Squires, S. (1988). The stoplight diet for children: An eight-week program for parents and children. New York, NY: Little, Brown.

8. Is your approach backed by evidence of success? If so, what is it? (300 words)

Health behavior interventions can reduce risk of diabetes among high-risk populations (1, 2) and have been effectively implemented in many community settings (3-5). The church is a good setting for programs targeting African Americans because of its central role in African American communities (6); high attendance rates (7); and reported trust among church members in scripture-based health messages (8).

The church setting has been used for many health promotion programs targeting adults (9-13), but not as frequently to target youth (14, 15). Sunday school has been used for a

few health interventions (16, 17), but to our knowledge has not been used for diabetes prevention efforts.

Use of Sunday school teachers to deliver our intervention is supported by research demonstrating the ambassador-model can be used successfully to deliver health interventions in African American churches (18-20). Qualitative research suggests most African American church members do not want outside experts delivering interventions (9).

Sunday school lessons will be based on methods from other successful programs. Baranowski et al. (2000) increased fruits and vegetable consumption in a school setting through methods included in our program: role-playing; recipe preparation; videos of health role models; and grocery store tours (21). Epstein et al. used the Traffic Light Diet to achieve long-term behavior change and weight loss among youth (22). Adaptations of this diet have also proven successful (23).

Epstein et al. found unstructured exercise (e.g., walking) is more effective than structured exercise (e.g., exercise class) in achieving increased physical activity (24). Hardman et al. (2010) demonstrated children's daily physical activity could be increased through use of pedometers, personalized step targets, and peer modeling (25).

Several of our program activities involve caregivers. Youth health behaviors improve most in family-based programs (26, 27), with some research suggesting this is particularly true among minority groups (15, 28).

Question 8: References

1. Pan X. R., Li G. W., Hu Y. H., et al. (1997). Effects of diet and exercise in preventing NIDDM in people with impaired glucose tolerance: the Da Qing IGT and Diabetes Study. *Diabetes Care*. 20:537–544.

2. Diabetes Prevention Program Research Group: The Diabetes Prevention program: reduction in the incidence of type 2 diabetes. *N Engl J Med*. 2002;346:393–403.

3. Ackermann, R. T., Marrero, D. G. (2008). Adapting the diabetes prevention program lifestyle intervention for delivery in the community: the YMCA model *Diabetes Educ*, 33 (69), 69-78.

4. Katula, J. A., Vitolins, M. Z., Rosenberger, E., Blackwell, C., Morgan, T., Lawlor, M., et al. (2011) One-year results of a community-based translation of the diabetes prevention program: Healthy-Living Partnerships to Prevent Diabetes (HELP PD) project. *Diabetes Care*, 34 (7),1451-1457.

5. Seidel, M. C., Powell, R. O., Zgibor, J. C., Siminerio, L. M., & Piatt, G. A. (2008). Translating the Diabetes Prevention Program into an urban medically underserved community: a nonrandomized prospective intervention study. *Diabetes Care*, 31 (4), 684-689.

6. Lasater T., Becker D., Hill M., Gans K. (1997). Synthesis of findings and issues from religious-based cardiovascular disease prevention trials. *Ann Epidemiol.* 7(Suppl 7):S46–S53.

7. Kramer M. K., Miller R., Venditti E., Orchard T. J. (2006). Group lifestyle intervention for diabetes prevention in those with metabolic syndrome in primary care practice. *Diabetes*. 55: Supp:A517.

8. Campbell, M. K., Resnicow, K., Blakeney, N., & Baskin, M. (2007). Church-based health promotion interventions: Evidence and lessons learned. *Annu Rev Public Health*, 28, 213-234.

9. Markens, S., Fox, S. A., & Gilbert, M. L. (2002). Role of black churches in health promotion programs: Lessons from the Los Angeles mammography promotion in churches program. *Am J Public Health*, 92(5), 805-810.

10. Baskin, M. L., Resnicow, K., Campbell, M. K. (2001) Conducting health interventions in black churches: a model for building effective partnerships. *Ethn Dis*, 11, 822-833.

11. Bopp, M., Wilcox, S., Laken, M., & McClorin, L. (2009). Physical activity participation in African American churches. *Journal of Cultural Diversity*, 16, 26–31.

12. Isaac, E. P., Rowland, M. L., & Blackwell, L. E. (2007). Fighting health disparities: The educational role of the African American Church. *Cross Currents*, 57(2), 261-265.

13. DeHaven, M. J., Hunter, I. B., Wilder, L., Walton, J. W., & Berry, J. (2004) Health Programs in Faith-based Organizations: Are They Effective? *Am J Public Health*; 94(6): 1030-1036.

14. Resnicow, K., Taylor, R., Baskin, M., & McCarty, F. (2005). Results of Go Girls: A weight control program for overweight African American adolescent girls. *Obesity Research*, 13, 1739-1748.

15. Thompson, W. M., Berry, D., & Hu, J. (2012). A church-based intervention to change attitudes about physical activity among black adolescent girls: A feasibility study. *Public*

Health Nurs., 30(3), 221-230.

16. Griffith, D. M., Campbell, B., Allen, J. O., Robinson, K. J., Robinson, K. J., & Stewart, S. K. (2010). Your blessed health: An HIV-prevention program bridging faith and public health communities. *Public Health Reports,* 125 (1).

17. Trost, S. G., Tang, R., & Loprinzi, P. D. (2009). Feasibility and efficacy of a church-based intervention to promote physical activity in children. *J Phys Act Health*, 6(6), 741-749.

18. Hunt, C. W., Grant, J. S., & Appel, S. J. (2011). An Integrative Review of Community Health Advisors in Type 2 Diabetes. *J Community Health,* 36:883-893.

19. Faridi, Z., Shuval, K., Njike, V. Y., Katz, J. A., Jennings, G., Williams, M., et al. (2009). Partners reducing effects of diabetes (PREDICT): A diabetes prevention physical activity and dietary intervention through African-American churches. *Health Education Research,* 25, 306-315.

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21. Baranowski, T., Davis, M., Resnicow, K., Baranowski, J., Doyle, K., Lin, L. S., Smith, M., & Wang, D. T. (2000). Gimme 5 Fruit, juice, and vegetables for run and health: Outcome evaluation. *Health Educ Behav,* 27:96.

22. Epstein, L. H., & Squires, S. (1988). The stoplight diet for children: An eight-week program for parents and children. New York, NY: Little, Brown.

23. Ellis, R. M., & Ellis, R. T. (2007) Impact of traffic light nutrition tool in a primary school. Perspectives in Public Health, 127(1), 13-21.

24. Epstein, L. H., Wing, R. R., Koeske, R., Ossip, D., & Beck, S. (1982) A comparison of lifestyle change and programmed aerobic exercise on weight and fitness changes in obese children. Behavior Therapy. 13, 5, 651-665.

25. Hardman, C. A., Horne, P. J., & Lowe, C. F. (2009) Effects of rewards, peer-modeling and pedometer targets on children's physical activity: A school-based intervention study. *Psychology and Health.* 26:1, 3-21.

26. Gruber K. J., Haldeman L. A. (2009) Using the family to combat childhood and adult obesity. *Prev Chronic Dis.* 6:A106.

27. Barr-Anderson, D. J., Adams-Wynn, A. W., DiSantis, K. I., & Kumanyika, S. (2012). Family-focused physical activity, diet and obesity interventions in African-American girls: A systematic review. *Obesity Reviews,* 14, 29-51.

28. Wilson D. K. (2009) New perspectives on health disparities and obesity interventions in youth. *J Pediatr Psychol* 2009; 34: 231-244.

Tracking to Success

9. How will you know when your impact has been achieved? What information or evidence will you use to verify success and/or make course corrections in your program? (500 words)

It is important that we evaluate the impact of our program in order to make program adjustments and determine if the achieved impact is significant enough to justify implementation on a larger scale. Level of success will be measured by changes in impact measures achieved during the program. Program impact will be evaluated via a process evaluation and an impact evaluation.

We will implement our program during two phases (*see Appendix*). Phase one will include program implementation in four churches, followed by an impact evaluation. We will take two months to review and interpret evaluation results and make program improvements. We will conduct focus groups with stakeholders to help make program improvements. Phase two will include implementation of the improved program in four new churches, followed by a post evaluation.

Our process evaluation will include obtaining and reviewing attendance records and documentation of program tasks completed during each phase. Attendance will be documented for weekly church services, Sunday school classes, and all other program-related events (e.g., Family Night, health screening event). Attendance records will be used to assess impact associated with various levels of participation in our program. Sunday school teachers will document program tasks completed during Sunday school each week. Live Empowered ambassadors will document program tasks completed during all other program-related activities.

Impact evaluation methods include pre- and post-tests to assess changes in eating behaviors and physical activity levels achieved during our program. Pre- and post-tests will be age appropriate with different tests for children, adolescents, and caregivers. Pre-

tests will be administered prior to program start date, and the entire congregation will be asked to participate. Post-tests will be administered on the final Sunday of each implementation phase.

Pre- and post-test questions will assess healthy eating behaviors and physical activity levels. Specifically, questions will assess behaviors associated with primary impact measures being evaluated: fruit and vegetable consumption patterns, sugar-sweetened beverage consumption patterns, and daily physical activity levels.

All data received from evaluations described here will be input into a Microsoft Excel worksheet and imported into SPSS software for data analysis. Results will be summarized and reported to all stakeholders.

10. What do you most want to learn from this program? (300 words)

1) We want to learn how program components described here improve the impact of Live Empowered in this community. We are also interested in learning if all program components are necessary to achieve significant impact.

2) We want to determine if a version of the Traffic Light Diet adapted for Sunday school can be used to improve eating behaviors among youth. To our knowledge this diet has not been used in this setting.

3) We want to learn if methods used by Hardman et al. (2009) to increase physical activity levels among children via a school setting can also achieve significant results when implemented in a Sunday school setting (1).

Question 10: References

1. Hardman, C. A., Horne, P. J., & Lowe, C. F. (2009) Effects of rewards, peer-modeling and pedometer targets on children's physical activity: A school-based intervention study. *Psychology and Health.* 26:1, 3-21.

Budget

EXPENSES – 12 months						
a. PERSONNEL	**Months**	**%FTE**	**Salary**	**Fringe**	**Total Cost**	**Trust Funds**
Program Coordinator	12	50.0%	$25,000	$7,500	$32,500	$32,500
Live Empowered Ambassadors	3	NA	In kind	$0	$0	$0
Sunday school teachers ($100 gift certificates x 8 churches)	3	NA	$800	$0	$800	$800
Nutrition Experts for Family Night events ($50 gift certificates x 8 churches)	4	NA	$400	$0	$400	$400
Total Personnel	NA	NA	$26,200	$7,500	$33,700	$33,700
b. EQUIPMENT				**Expense**	**Total**	**Trust Funds**
Kitchen equipment (e.g., refrigerator, microwave)				In kind		$0
Projectors (4 churches x $400 per item)				$1,600		$0
Total Equipment					$1,600	$1,600
c. SUPPLIES				**Expense**	**Total**	**Trust Funds**
Blood pressure machine				In kind		$0
Blood glucose monitor and test strips				In kind		$0
Stadiometer				In kind		$0
Tables and chairs				In kind		$0
Educational materials for health screening events				$240		$0
Pedometers (1,200 participants x $6.00 per unit)				$7,200		$7,200
Journals (1,200 participants x $2.50 per unit)				$3,000		$3,000
Program materials for Sunday school lessons (8 churches x 8 lessons x $15 per lesson materials)				$960		$960
Food items for cooking lessons during Sunday services (2 snack events per church x 1,200 participants x $2.50 per snack)				$6,000		$6,000
Materials for cooking demonstration – Family Night event (8 churches x $150 per event)				$1,200		$1,200
Kitchen equipment (e.g., cutting board, utensils)				In kind		$0
Office supplies (e.g., pens, paper, staples)				$500		$0
Total Supplies					$19,100	$18,360

d. TRAVEL				Expense	Total	Trust Funds
Mileage for Program Coordinator between the ADA and Wilson County (Rate of $0.50/mile)				$2,100		$2,100
Total Travel					$2,100	$2,100
e. OTHER EXPENSES				**Expense**	**Total**	**Trust Funds**
Printing/photocopying ($60/month x 12 months)				$720		$720
Project specific postage ($20/month x 12 months)				$240		$240
Contract with videographer to film and edit 8 videos with health tips featuring African American mentors				$3,000		$3,000
Total Other					$3,960	$3,960
TOTAL DIRECT COSTS					$60,460	$59,720
TOTAL INDIRECT COSTS					$6,046.00	$0
TOTAL BUDGET					$66,506	$59,720

Budget Justification

a. Personnel

Program Coordinator

Required credentials: MPH preferred
Required skills: Proficient in Microsoft Excel, Microsoft PowerPoint, and SPSS
FTE: 50%
Job duties: The program coordinator will be hired by the American Diabetes Association's office in Raleigh, North Carolina. This position will require an average of about 20 hours/week (50% FTE) for a 12-month period with the first three months being the most labor intensive. During the first three months of the grant period, the program coordinator will recruit eight churches; lead training sessions for church ambassadors; and develop Sunday school lesson materials and evaluation materials. Development of program materials will include investigating current programs in the community that have possibility of being used with modifications. The program coordinator will also be expected to conduct focus groups and key informant interviews to assist in program development. Evaluation materials will be developed with assistance from ADA subcommittees. During the implementation phase, the program coordinator will assist church ambassadors with issues and all needed lesson materials are provided. The program coordinator will be responsible for working with churches and local health clinics to plan and implement health fairs. The program coordinator will also be responsible for working with local grocery stores to plan and implement the Family Night events. Upon conclusion of phase one of the program, the program coordinator will analyze evaluation surveys and supervise meetings aimed at improving Live Empowered, Youth Edition. During the final three months of the grant period, the program coordinator will analyze and summarize all evaluation results and report results to stakeholders. The program coordinator will be compensated as follows:

$50,000 x (50% FTE) = $25,000 + $7,500 (fringe) = $32,500 for the one-year grant period.

Live Empowered Ambassadors

There will be at least eight individuals in this position. Most churches will have one person in this position, but a few may have more than one. Individuals in this position will perform tasks associated with the ADA's Live Empowered program (e.g., workshops). This individual will also assist with a few tasks outlined in this grant application, including assisting with implementation of the health fair. This individual may also present short health information lessons at the beginning of the church service. However, in some congregations, the pastor may perform this task. This position has been an in-kind contribution for the past five years that Live Empowered has been implemented, and we do not anticipate the added tasks described in this grant application will prevent this position from remaining in-kind.

Sunday School Teachers

A Sunday school teacher will be recruited from each church. We hope to recruit the current Sunday school teacher. Sunday school teachers will attend a two-hour training session prior to program implementation. Sunday school teachers will teach program lessons in place of regularly scheduled activities. Sunday school teachers will also lead four lessons that include caregiver participation. Sunday school teachers will receive $100 gift certificates upon program conclusion. Therefore, 8 Sunday school teachers x $100 gift certificate = $800.

Nutrition Ambassadors

Individuals from the African American community with a strong background in health and nutrition will be recruited for this position. Nutrition Ambassadors will lead grocery store tours associated with Family Night. Individuals in this position will attend a two-hour training session to prepare for Family Night. Nutrition experts will be compensated with a $50 gift certificate for each grocery store tour. Therefore, 8 churches x 1 Family Night event per church x $50 gift certificate = $400.

Total for all personnel: $33,700

b. Equipment

Kitchen equipment (e.g., refrigerator, microwave) will be used to store and prepare snacks supplied during two Sunday services per church.

Funds totaling $1,600 are requested to purchase four projectors. These projectors will be loaned to four churches per intervention phase. The projectors will be used to project lesson materials during Sunday school (e.g., health videos created for this program). Therefore, 4 projectors x $400 per projector = $1,600.

Total for equipment: $1,600

c. Supplies

Medical supplies for the health fair will be provided as an in-kind contribution from the local health clinic. Medical supplies provided will include a blood pressure machine, blood glucose monitors, and a stadiometer.

Tables and chairs for the health fair and for program-related classes will be provided as in-kind contributions from participating churches.

Educational materials for the health-screening events and office supplies will be provided in-kind by the American Diabetes Association. Educational materials will include handouts related to diabetes risk factors and disease management information. Office supplies include pens, pencils, staples, ink, etc. These items will be used to conduct volunteer training sessions, health screening events, Family Night events, etc.

Funds totaling $7,200 are requested to purchase the 1,200 pedometers needed for the estimated number of regular church attendees. Therefore, 1,200 participants in the Step Challenge x $6.00 per pedometer = $7,200.

Funds totaling $3,000 are requested to purchase the 1,200 journals needed for the Step Challenge. These journals will also provide eating guidelines associated with the Traffic Light Diet. Therefore, 1,200 participants x $2.50 per journal = $3,000.

Funds totaling $960 are requested to purchase program materials for Sunday school lessons (e.g., props, game materials). Therefore, 8 Sunday school lessons x 8 churches x $15 per lesson = $960.

Funds totaling $6,000 are requested to purchase food items needed for youth cooking lessons. Youth will prepare snacks for themselves and their caregivers. Therefore, 1,200 participants (youth and caregivers) x $2.50 per snack x 2 snack events per church = $6,000.

Funds totaling $1,200 are requested to purchase food items needed for healthy cooking demonstration for the Family Night event. Each church will complete one Family Night event during the course of this program. We estimate each church will require $150 to purchase snack items for 45% of regular attendees, which is the number of people we estimate will attend this event. Therefore, $150 per event x 8 churches = $1,200.

Small kitchen tools needed to prepare snacks (e.g., cutting board, utensils) will be supplied as in-kind contributions by churches participating in this program.

Total for supplies: $18,360

d. Travel

Funds totaling $2,100 are requested to provide reimbursement at a rate of 50 cents per mile for the program coordinator, who will be based out of the American Diabetes Association office in Raleigh, North Carolina, and will travel to Wilson County, North Carolina, for many program related-events: 8 Family Night events; 8 health fairs; 10 trips to recruit churches; 6 trips for program development efforts, including leading focus groups and key informant interviews; 5 trips to lead training sessions; 4 trips to provide materials for snack events. We estimate this will require 41 round trips to Wilson County during the 12-month grant period and additional funds for driving between churches for specific events, such as delivering snack materials. It is approximately 50 miles from the ADA office in Raleigh to Wilson County. Therefore, travel amount was calculated as follows:

(41 trips x 2 ways x 50 miles x $0.50/mile) + (100 miles driving between churches x $0.50/mile) = $2,100.

Total for travel: $2,100

e. Other Expenses

Funds totaling $720 are requested for the 12-month grant period ($60/month) to print and photocopy materials needed for 5 training sessions; 8 health fairs; 8 Family Night events; 64 Sunday school lessons; and all evaluation materials.

Funds totaling $240 are requested for project specific postage. We anticipate frequent events in which churches will need materials mailed to them during the implementation phase. We will also use these funds to provide paid postage to allow churches to send completed evaluation surveys to the ADA office.

Funds totaling $3,000 are requested to secure a contract with an experienced videographer to film and edit 8 video clips that feature health tips presented by African American mentors. Health clips will be played during each Sunday school lesson.

Total for other: $3,960

TOTAL DIRECT COSTS: $59,720

INDIRECT COSTS @ 10% = $6,046

TOTAL BUDGET (Kate B. Reynolds): $59,720*

(*Note: Indirect costs were not included in total budget, per instructions by Kate B. Reynolds grant application guidelines. Grant reviewers will add indirect costs, if approved.)

Appendix

GRANT PERIOD TIMELINE (AUG 2014 – JULY 2014)