#198

COMPLETE

Collector:	Gimbel Foundat...nd Evaluation (Web Link)
Started:	Thursday, March 14, 2019 1:07:35 PM
Last Modified:	Friday, March 15, 2019 8:15:30 PM
Time Spent:	Over a day
IP Address:	107.221.200.81

Page 1

Q1 Name of your organization.

The Cambodian Family

Q2 Grant #

20170710

Q3 Grant Period

11/01/2017 - 02/19/2019

Q4 Location of your organization

City	**Santa Ana**
State	**CA**

Q5 Name and Title of person completing evaluation.

Amina Sen-Matthews, Director of Health Programs

Q6 Phone Number:

714-571-1966 ext. 117

Q7 Email address.

aminasm@cambodianfamily.org

Page 2: Key Outcomes and Results

Q8 Total number of clients served through this grant funding:

221

Q9 Describe the project's key outcomes and results based on the goals and objectives. Use the following format:State the Goal:State Objective 1:Describe the Activities, Results and Outcomes for Objective 1:State Objective 2 (if applicable):Describe the Activities, Results and Outcomes for Objective 2:State Objective 3 (if applicable):Describe the Activities, Results and Outcomes for Objective 3:

Goal: To increase access of underserved, low-income, Limited-English-Proficient Cambodian residents of Orange County to culturally and linguistically appropriate preventive health and health care services, information, and resources.

Objective #1: By February 2019, 90 individuals will receive health education to help improve their knowledge, attitude, behaviors, and/or skills regarding heart disease/stroke and diabetes.

Activities #1: In partnership with our existing community partners such as the University of California's Nutrition Expanded Program, St. Joseph Heritage, and CalOptima, we provided both individual and group health education workshops. Participants learned about signs and symptoms of heart disease and stroke, diabetes, and other important health topics such as how health related problems can be prevented or mitigated by greater awareness, early detection and treatment, careful management, and changes in lifestyle or behavior. They learned about factors that contribute to preventing and successfully managing health issues. Participants of this program were also provided with resources and materials within the community.

Results #1: We have significantly exceeded our goal due to leveraged resources and partnerships. We provided 296 health education contacts to a total of 221 unduplicated participants, exceeding our goal of serving 90. With respect to the importance of preventive health, health screening, and regular medical check-up. We found that in order for some of our participants to fully grasp the health education, they may have to attend more than once. Thus, some participants attended multiple times and each time they attended, they completed a survey.

Final Grant-End Outcome #1: By February 19, 2019, 68 participants (75%) attending group and individual health education sessions will report improved health knowledge, attitude, behaviors, or skills.

A total of 296 health education surveys were collected, as some of the participants attended the health education more than once. Based on the immediate post-test survey results:
• 97% of participants (289/296) reported that they learned new information after attending the workshop.
• 98% of participants (289/296) reported that they learned new information about heart disease and stroke, diabetes, the importance of preventative health, and the importance of being physically active and healthy eating.
• 91% of participants (271/296) reported that they learned new ways to improve their diet.
• 93% of participants (277/296) reported that they were more prepared to ask their doctor questions about their health.
• 95% of participants (282/296) reported that they would be making changes to their diet after the workshop.
• 97% of participants (286/296) reported that they were satisfied or very satisfied with our health education, which was taught by a Khmer-speaking medical doctor.

Objective #2: By February 19, 2019, 75 individuals will receive case management/health navigation services to help increase participants' access to preventive health/health care services & resources.

Activities #2: Participants, particularly culturally and linguistically isolated seniors, received personal counseling, ongoing support, preventive health, and health care accessing services from our bilingual/bi-cultural health navigators. The Health Navigator (HN) helped make appointments for clients, accompanied them to their medical appointments, interpreted/translated and ensured effective communications with medical providers, advocated for and asked questions on behalf of clients who lacked the communication skills, explained treatment regimens to clients, and supported them and followed-up through phone calls and in-person meetings to ensure that

participants understood. Appointments included health screenings, medical visits, and social/support visits.

Results #2: We provided 266 case management to 153 unduplicated participants. As a result, we were able to help participants understand the significance of their doctor's visit and what the vital numbers mean. We were also able to improve communications with their providers through providing translation and interpretation and cultural competency education. We helped make clients aware of what needed to be done to prevent and/or manage their diabetes, high blood pressure, and/or stroke and provided transportation when needed so that they could access preventive health and health care services in a timely manner.

Final Grant-End Outcome #2: By February 19, 2019, 56 enrolled participants (75%) will report improved access to preventive health and health care services, as a result of our case management and health navigation services.

Based on results from the baseline and follow-up surveys, we have found that:
• At baseline, 30% of respondents (46/153) reported that it was "easy" when obtaining health care services, compared to 74% (110/150) at follow up as a result of our case management and health navigation services.
• At baseline, 58% of respondents (89/153) reported at least 5 barriers that made it difficult for them to get health care services. These barriers were language, transportation, filling out medical forms, and making appointments, compared to only 16% (24/150) at follow up.
• At baseline, 3% of respondents (4/153) reported that they did not have any medical insurance compared to 1% (1/150) at follow up. We were able to help participants apply for health insurance such as MediCal.

Objective #3: By February 2019, 2019, 40 individuals will attend nutrition education and healthy cooking demonstration classes to help promote healthy behaviors.

Activities #3: We organized nutrition education workshops which included topics related to USDA's new "My Plate" concept, the importance of each of the plate sections, and the importance of portion size. We worked with the University of California's Expanded Nutrition Program to provide nutrition education. Also, we organized healthy cooking classes that demonstrated healthy food recipes that were culturally appropriate from the Guide to Healthy Eating for Cambodian Americans cookbook. Our volunteer community health ambassadors were the ones who ran the cooking class. Participants learned new and healthy recipes, enjoyed samples of healthy food, and each received a copy of the recipes.

Results #3: We provided 53 participants with nutrition and healthy cooking demonstration classes that were taught by a Nutrition Educator from the University of California, Irvine. We also engaged our community members to help run a cooking class together with our health navigator in which they were able to share with their peers how they made dishes that are normally unhealthy healthy by lessening the amount of sugar and salt intake. We hosted 4 nutrition education classes and 3 cooking classes that focused on reducing the amount of salt and sugar and adding more vegetables and fruits to your meal.

Based on results from baseline and follow-up surveys, we have found that:
• At baseline, 53% of respondents (28/53) reported that their salt intake was "a lot or "quite a bit," compared to 19% (10/53) at follow up.
• At baseline, 59% of respondents (31/53) reported that their sugar intake was "a lot or "quite a bit," compared to 13% (7/53) at follow up.
• At baseline, 47% of respondents (25/53) reported that their fat and or high calorie food intake was "a lot or "quite a bit,", compared to 11% (6/53) at follow up.
• At baseline, 88% of respondents (47/53) reported that they spent on average 3 times per week and 20 minutes per time doing physical activity, compared to 98% (52/53) at 5 times per week and 30 minutes per time at follow up.

Q10 Please describe any challenges/obstacles the organization encountered (if any) in attaining goals & objectives.

There were no major challenges in achieving our objectives reported during this grant period. We have obtained many lessons learned and best practices from implementing Healthy Changes Program in the previous years. However, the only challenge that was presented by our clients was transportation to attend our program activities and access health care services.

Q11 How did you overcome and/or address the challenges and obstacles?

To address this transportation challenge, we provided on-site health screening with our community partners, First Street Pharmacy and Heritage St. Joseph. We hosted some of the program activities such as health education and healthy cooking demonstration classes at the apartment complex where our clients reside. We encouraged our clients to carpool with other clients who drove. Moreover, our health navigators helped provide transportation when needed.

Q12 Describe any unintended positive outcomes as a result of the efforts supported by this grant.

As we reflect on this important program, we have found that one of the unintended outcome results was the emotional and physical supports that were naturally created and offered amongst our participants who attended program activities such as group exercise classes, walking club, healthy cooking demonstration classes. Program participants helped motivate each other to increase their participation in the program and took charge of their own health, which resulted in better health outcomes.

Q13 Briefly describe the impact this grant has had on the organization and community served.

The support from The Community Foundation's S.L. Gimbel Foundation Fund has helped increase our capacity to respond to the growing needs of our underserved community members in Orange County. With the support from the Foundation and additional resources leveraged during the grant period, we were able to increase our capacity to serve over 200 participants, exceeding our goal of just serving 90 participants and almost all of our outcome measures. Moreover, the grant helped us to continue to provide the most needed programs and activities that helped the underserved and limited English proficient participants increase their healthy lifestyle knowledge and behaviors and reduce the risk factors for chronic diseases such as heart disease, stroke, diabetes, hypertension, and depression.

Page 3: Budget

Q14 Please provide a budget expenditure report. Also, provide a budget narrative that explains how the funds were utilized, what was purchased, what were the expensed items based upon the budget that was submitted.

The funds were used to support our Healthy Changes Program's staff salaries, payroll taxes, and benefits, rent, office/program supplies, including health education materials and other program related expenses as indicated in the budget proposal approved by the Foundation. Please see the attached budget expense report sent by e-mail to grant-info@thecommunityfoundation.net.

Page 4: Success Stories

Q15 Please relate a success story:

VH is a 61-year-old Cambodian woman who speaks limited English and does not know much about strategies she can take to care for her physical and mental health. We worked with VH on her health as she was told by her doctor that she had high blood pressure and high cholesterol. Before enrolling in our program, VH had a blood pressure level of 178/90 and glucose level of 108. She was very concerned about her health and asked our health navigator to help her find ways to lower them. Our health navigator provided her with one-on-one health education on how she could start living a healthy lifestyle and what she needed to know in order to do so. VH started attending our exercise class 3 times a week and exercised at home the rest of the time. She regularly attended our health education workshops on diabetes and heart diseases, nutrition and healthy cooking classes, and wellness activities. VH was so motivated to make changes to her health by increasing her participation in our program. She attended our 8 session nutritional classes, where she learned how to read nutritional values and how to measure food intake. She also learned how to read newspaper ads to find the best deals on healthy food. After learning about the different steps she could take to lower her blood pressure and glucose levels, VH registered to receive health screening at our center. Upon her follow-up health screening, her blood pressure and glucose level had dropped significantly. VH's blood pressure went down from 178/90 to 159/82 and her glucose level went down from 108 to 92. She said, "this program has made me really pay attention to my health and has offered me so many ways that I can be healthy. Now I understand what it means to live a healthy lifestyle. I have grand kids and I want to be able to be around for them. Thank you for helping me."

Q16 Please relate a success story here: **Respondent skipped this question**

Q17 Please relate a success story here: **Respondent skipped this question**

Page 5: Organizational Information

Q18 Which category best describes the organization. Please choose only one.

Service Organization

Q19 What is the organization's primary program area of interest?

Health & Human Services

Q20 Percentage of clients served through grant in each ethnic group category. Total must equal 100%

African American	**0**
Asian/Pacific Islander	**100**
Caucasian	**0**
Native American	**0**
Hispanic Latino	**0**
All Ethnicities	**0**
Other	**0**
Unknown	**0**

Q21 Approximate percentage of clients served from grant funds in each age category.

Children Birth-05 years of age	**0**
Children ages 06-12 years of age	**0**
Youth ages 13-18	**0**
Young Adults (18-24)	**5**
Adults	**70**
Senior Citizens	**25**

Q22 Approximate percentage of clients served with disabilities from grant funds.

No clients served with disabilities	**0**
Physically Disabled	**1**
Blind & Vision Impaired	**0**
Deaf & Hearing Impaired	**1**
Mentally/Emotionally Disabled	**0**
Learning Disabled	**0**
Speech Impaired	**0**
Other Disability	**0**

Q23 Approximate percentage of clients served in each economic group.

At/Below Poverty Level	**90**
Homeless/Indigent	**0**
Migrant Worker	**0**
Working Poor	**10**
Other	**0**

Q24 Approximate percentage of clients served from grant funds in each population category.

Single Adults	**5**
Families	**90**
Single Parent Families	**3**
Disabled	**3**
Ethnic Minority	**100**
LGBTG	**0**
Abused Women/Children	**0**
Homeless/Indigent	**0**
Immigrants	**95**
Military	**0**
Parolees	**0**
Students	**0**
Elderly	**25**
Children/Youth (those not included in Family)	**0**