

**FY 2002 Boilerplate Report  
Improving Health of African American Men  
Section 1011 (2)**

**African American Initiative for Male Health Improvement (AIMHI)**

It is estimated that over 436,000 adults in Michigan have been diagnosed with diabetes and that an additional 213,400 Michigan adults have diabetes but are not aware of it. It is the seventh leading cause of death for Michigan residents. There are 84,000 African Americans with diagnosed diabetes in Michigan (Rate: 8.7 per 100). (Source: MDCH Diabetes in Michigan Fact Sheet, August 2000). Diabetes is one of the leading chronic illnesses in African Americans and accelerates heart disease. African Americans also experience higher rates of the complications of diabetes such as kidney disease, amputations and blindness.

The African American Initiative for Male Health Improvement (AIMHI) was started in 1998 and is conducted in traditional black churches, neighborhoods with a large proportion of older African American men who may be homebound, barber shops and other locations. Patient centered interventions are targeted and tailored for African American men. The program was developed based on the assessment of health trends of the Michigan population. One of the four priorities of the plan was to improve the survival of African American males with a focus in four major areas: diabetes, hypertension, glaucoma and other eye disease; stroke risk factors; and cancer or other diseases in later years.

The project seeks to improve the health of African American men (and women) in the city of Detroit and surrounding areas through community based prevention, early detection, health education and care initiatives targeted at diabetes, hypertension, stroke and eye diseases. Funds are given to the Center for Medical Effectiveness Programs in Diverse Populations at Henry Ford Health System

The project has 6 objectives:

1. Deliver diabetes, hypertension, stroke risk assessment and eye screening services.
2. Provide Diabetes Self-Management Education Classes to people with diabetes.
3. Implement a stroke prevention program.
4. Develop a Diabetes "Report Card".
5. Develop collaborative partnerships to assist in implementing the screening clinics and programs.
6. Develop and administer process and outcome evaluation efforts.

The project accomplishments for FY 2001 included the following:

1. Provided screenings to 2500 persons for diabetes, hypertension and stroke risk and provided follow-up on 521 people who were screened with abnormal results for high glucose levels and high blood pressure readings.
2. Provided screenings to 532 persons for the eye care services component with follow-up conducted on 218 people.
3. Conducted diabetes self-management education classes to 80 participants.
4. Provided counseling and educational information to participants who screened moderate or high on the stroke risk assessment.
5. Developed partnerships and collaborated with agencies to provide 60+ health screenings.
6. Worked closely with the Racial and Ethnic Approaches to Community Health (REACH) partnerships.
7. Worked on the development of Diabetes "Report Card" to determine what diabetes measures the community regards as important to care.

The project goals for FY 2002 include the following:

1. Provide screenings for 2800 persons for diabetes, hypertension and stroke risk.
2. Provide screenings to 70 persons for the eye care services component.
3. Conduct diabetes self management classes for 90 participants
4. Continue to partner with REACH and other community agencies.

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