DIABETES IN HUMBOLDT PARK:

A Call to Action

December 6, 2006

Prepared by

THE HUMBOLDT PARK DIABETES TASK FORCE

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EXECUTIVE SUMMARY

In "Disproportionate Impact of Diabetes in a Puerto Rican Community in Chicago," appearing in the December 2006 issue of the *Journal of Community Health,* Steve Whitman, Abigail Silva and Ami Shah, from the Sinai Urban Health Institute, identified the excess burden of illness that diabetes places on the people of Humboldt Park, most notably the Puerto Ricans. In response to the findings of that paper, over 20 health professionals and community activists met to develop an action plan that would significantly reduce diabetes morbidity in Humboldt Park within five years. Meeting over a three month period, this task force has generated 19 recommendations to be implemented over the next five years as part of a newly formed **Humboldt Park Diabetes Project**. Each recommendation of the task force was based not only on the best available evidence and research, but also on the principal that community engagement and participation in the plan will be essential to its success.

The 19 recommendations in the report address five major goals:

1. To increase awareness of diabetes and make it a community-wide priority;
2. To design and implement a screening program to define the scope of the problem within the community;
3. To reduce the number of people who develop diabetes in the community through a multifaceted program of education and primary prevention;
4. To improve medical care and access to health services for people with diabetes;
5. To provide people with diabetes with the necessary information and resources to thus empower them to take better care of their health.

Diabetes is not inevitable or unavoidable. Healthy lifestyles, early and effective medical treatment, and behavioral self-management for people affected by diabetes can all dramatically reduce morbidity (complications) and mortality (death). While it will take many years to eliminate the excess death rate from diabetes, the Humboldt Park Diabetes Project is committed to working with the community to significantly reduce diabetes morbidity within the next five years. This is more than a public health challenge – this is a moral imperative for all of us. The Humboldt Park Diabetes Project calls on the participation of the entire community in this

challenge: political leaders at the city, state, and federal level; the philanthropic community; public health authorities from the Illinois and Chicago Departments of Public Health; academic health centers and universities; hospitals, clinics, and doctors in this community; the media; community organizations, religious institutions, businesses, and other agencies; and all of the residents of Humboldt Park.

We further believe that this strategy will not only help the residents of Humboldt Park but will serve as a model for other communities in Chicago and indeed the United States. To facilitate this process, we are working with experts in the evaluation of community health projects who will help us determine just what is most effective in this pursuit.

We must all work together in the fight against diabetes.

We have a plan. The time for action is now.

INTRODUCTION

The paper entitled "Disproportionate Impact of Diabetes in a Puerto Rican Community in Chicago" set to appear in the December 2006 issue of the *Journal of Community Health* was meant by the authors from the Sinai Urban Health Institute to be a call to action. Indeed, viewing it any other way would be a disservice to the people of the Humboldt Park community as well as to people in similar communities across the United States. It is to this call that our Diabetes Task Force is responding.

As the paper indicates, diabetes is extracting an enormous toll on the people of Humboldt Park, most notably the Puerto Ricans. The proportion of adults with diabetes (the prevalence) has increased rapidly in the United States and now stands at about 7%. Among Puerto Ricans in this community it is 21%, three times higher than the US rate and higher than almost any other diabetes prevalence that has ever been reported. Even worse, the diabetes mortality rate among Puerto Ricans in Humboldt Park is 68 per 100,000 people. This may be compared with a rate of 25 for the US and 31 for Chicago. The rate of 68 is so high that if it prevailed for the US, it would be the second leading cause of death in the country: higher than anything except heart disease, higher than any cancer, higher than stroke, etc. But the damage extends even further than this. Once people have diabetes they are at increased risk of kidney disease, (and kidney failure and dialysis), blindness; amputation; and much more.

Diabetes, however, does not stand immutable and triumphant. We know many ways to prevent diabetes. In cases where it cannot be prevented, we know many ways to minimize its impact and certainly to prevent it from killing us. It is to these actions that our Task Force has turned its attention. The challenge that we pose to ourselves is as follows: What can realistically be done to turn back the diabetes epidemic in Humboldt Park? Can we create a plan that will do this? And if we succeed, can we document our efforts so that they can be employed by similar communities across the country?

When the call went out to concerned people in the city, we never expected such a resounding response. Without exception, every person we asked to serve on this Task Force agreed,

attending meetings held at night and reading, writing, and researching the issues long after official work hours ended. A list of the Task Force members, along with their organizational affiliations, is detailed on page 1. As can be seen, this report represents the work of a diverse and highly qualified group.

This document contains recommendations for fighting diabetes in this one community. All of our recommendations are based on the best-informed evidence that we could locate; all of them are realistic and can be implemented – starting now. We hope that you will agree that this is indeed a blueprint for success. We have the knowledge and the capabilities. What we need now are the resources and the political will to free up those resources for what is literally a matter of life and death.

MISSION STATEMENT

Diabetes is not inevitable or unavoidable. Healthy lifestyles, early and effective medical treatment, and behavioral self-management for people affected by diabetes can all dramatically reduce morbidity (complications) and mortality (death). While it will take many years to eliminate the excess death rate from diabetes in the Puerto Rican community, the Humboldt Park Diabetes Project is committed to working with the community to significantly reduce diabetes morbidity within the next five years. This is more than a public health challenge – this is a moral imperative for all of us. The time for action is now.

The Humboldt Park Diabetes Project will:

1) **INCREASE AWARENESS OF THE IMPACT OF DIABETES AMONG RESIDENTS OF HUMBOLDT PARK AND WILL INCREASE UNDERSTANDING THAT DIABETES AND ITS COMPLICATIONS ARE PREVENTABLE AND TREATABLE.**
2) **CREATE A SUSTAINED PROGRAM OF CULTURALLY RELEVANT COMMUNITY EDUCATION TO INCREASE HEALTHY LIFESTYLES AND BEHAVIORS TO REDUCE THE RISK OF DIABETES.**
3) **IDENTIFY 1,000 NEW CASES OF DIABETES IN THE COMMUNITY SO THAT PEOPLE CAN BEGIN EFFECTIVE TREATMENT BEFORE THE DISEASE CAN DAMAGE THEIR HEALTH.**
4) **IMPROVE THE CONTROL OF DIABETES, DEMONSTRATED BY OBJECTIVE MEASURES, WITHIN THE NEXT FIVE YEARS.**
5) **REDUCE THE RATE OF DIABETES-RELATED HOSPITALIZATIONS AND COMPLICATIONS WITHIN THE NEXT FIVE YEARS.**

GUIDING PRINCIPLES

In preparing the recommendations in this report, we have observed the following general principles:

Diabetes is an urgent priority

- As shown in the paper by Whitman, Silva, and Shah at the Sinai Urban Health Institute, diabetes is already so prevalent as to overwhelm existing health resources and recent trends show that it is rising rapidly in Humboldt Park. Time is of the essence. Our proposals must be simple and ready to be implemented.
- Prevention is preferable to cure. Wherever possible, and supported by research, Primary Prevention should be emphasized to reduce the occurrence of diabetes – before it can cause sickness, disability, and death.

Community oversight and cultural sensitivity

- The impact of diabetes is felt throughout the community; the response to the problem must come from the community. Our best hope for both preventing diabetes and providing optimal care to persons with the disease rests with engaging and involving community members. Every aspect of the project must be informed by the community, using a mechanism such as the Centers for Disease Control and Prevention (CDC)'s PATCH (Planned Approach to Community Health) process; this approach "increases the capacity of communities to plan, implement, and evaluate comprehensive community-based health promotion programs."
- All efforts in the project must be culturally relevant; our efforts must go beyond simply producing materials in Spanish, but must also be sensitive to the values and beliefs of the residents of Humboldt Park.

Diabetes must be approached at all levels – prevention, early detection, and comprehensive care

- A large national prevention study, the Diabetes Prevention Project, has shown that as many as 60% of at-risk people can prevent diabetes through effective lifestyle interventions.

Others who are already diagnosed can benefit through self-management training. At the same time, medications will be needed by many residents to both prevent and treat diabetes and its complications. As this project will seek to identify persons with diabetes and those at risk, we must ensure that clinical resources -- and medications for the uninsured – are available in the community.

- Diabetes is a primary care disease – our strategy is not to shift patients from one source of care in the community to another source. Our proposals will seek to build the infrastructure to deliver good primary care.
- Proposals will be based on best current evidence of effectiveness.

Implementation

- The Humboldt Park Diabetes Project will seek immediate funding for a Director with public health experience and knowledge of the community. Office space and clerical support will be obtained through funding or in-kind support. This will represent the operational core of the Project, responsible for outreach and pursuing additional funding to implement the recommendations.
- Recommendations should be rolled out in a carefully thought out series of stages, with each effort building the infrastructure needed for the next step.
- Funding to initiate projects should be from multiple sources, both public and private. This funding will be considered start-up only; for each proposal, long-term sustainability is a key consideration.
- For each proposal, we will ensure that the benefits to the community can be well documented, and that information about our progress is shared with the community on a regular basis.

Evaluation and this Work as an Exemplar

- It is essential to note that we view this work as a model to be tested. We are concerned with diabetes in all communities, not just among Puerto Ricans, not just Humboldt Park, etc. However, our research has led us to this community and the data suggest that this is a crucial place to start.

- We will evaluate what we do very carefully, keeping track of our efforts, their impact on diabetes and related conditions, and cost effectiveness. Our Task Force is very well-qualified to lead such work.
- If our work succeeds and we are able to improve the situation in the project community, then we will have a well-documented effort that we could extend to other communities in Chicago and even nationally.

SUMMARY OF RECOMMENDATIONS

1. INCREASE AWARENESS OF DIABETES AND MAKE DIABETES A COMMUNITY-WIDE PRIORITY

1.1. Recruit an Oversight Board for the Humboldt Park Diabetes Project.

1.2. Engage community groups in the design and implementation of efforts to increase awareness of diabetes in the community.

1.3. Identify and train at least two outreach workers to conduct workshops and talk to individuals and groups about the impact of diabetes in the community.

1.4. Design and implement a social marketing campaign to promote awareness and action on diabetes in Humboldt Park.

2. DEFINE THE SCOPE OF THE PROBLEM WITHIN THE COMMUNITY

2.1. Design and implement a community-wide screening campaign for diagnosing persons with diabetes and also for those at risk of developing diabetes.

2.2. Prepare an annual report to the community about findings of the Screening Campaign.

3. PRIMARY PREVENTION: REDUCE THE NUMBER OF PEOPLE WHO DEVELOP DIABETES IN THE COMMUNITY

3.1. Establish a Diabetes Community Education Center (DCEC) in Humboldt Park.

3.2. Implement an intervention program for children identified as “at risk” through community screening programs.

3.3. Design and implement multifaceted interventions aimed at diet, physical activity, and behavior change based in worksites and other settings in the community.

3.4. For persons with pre-diabetes, provide effective early intervention to reduce the risk of developing diabetes.

4. IMPROVE MEDICAL CARE FOR PEOPLE WITH DIABETES

4.1. Engage health care providers serving Humboldt Park in a diabetes collaborative network to improve diabetes care.

4.2. Develop and implement an intensive diabetes quality care education project for health care providers.

4.3. Design and implement quality improvement projects across all of the members of the Humboldt Park diabetes collaborative network.

4.4. Conduct an annual clinical needs assessment to ensure adequate health system resources.

4.5. Implement diabetes clinical services at the Diabetes Community Education Center.

4.6. Implement a case management program for all persons with diabetes in Humboldt Park.

5. HELP PEOPLE WITH DIABETES TAKE BETTER CARE OF THEIR HEALTH

5.1. Implement a "diabetes information clearing house" within the DCEC to provide educational materials and referrals to community agencies

5.2. Provide free diabetes self-management education and resources for people diagnosed with diabetes.

5.3. Provide community-based resources to healthy decision-making regarding nutrition and physical activity for persons with diabetes and their families.

THE RECOMMENDATIONS

1. INCREASE AWARENESS OF DIABETES AND MAKE DIABETES A COMMUNITY-WIDE PRIORITY

The report of the Sinai Urban Health Institute has shown that diabetes takes a disproportionate toll on the Humboldt Park neighborhood. In order to correct this situation, residents must be aware of the problem, and must believe that they can correct this problem by taking action as individuals, as families, and as a community. The success of our campaign will depend upon a major effort to front-load awareness within the community and engage as many individuals as possible in the design and implementation of the Humboldt Park Diabetes Project.

1.1. ***Recruit an Oversight Board for the Humboldt Park Diabetes Project.***

The Board should include a wide range of representatives, including residents of the neighborhood, community based organizations (CBOs), representatives of the business community in Humboldt Park, health professionals and services, and public health officials to oversee the development and implementation of the project.

1.2. ***Engage community groups in the design and implementation of efforts to increase awareness of diabetes in the community***

HPDP will utilize a coalition of community partners that do valuable work in the Humboldt Park community and are already engaged in organizing around health issues. These include (but are not limited to) the Puerto Rican Cultural Center, Centro Sin Fronteras, Centro San Bonifacio, Association House, Bickerdike Redevelopment Corporation, Erie Neighborhood House, Miguel Barreto Union League Boys and Girls Club, the McCormick Tribune YMCA, the Chicago Park District (Humboldt Park), San Lucas Church, the Community of Wellness-HPEP/NNNN (Humboldt Park Empowerment Partnership-Near Northwest Neighborhood Network) Committee, CLOCC (Consortium to Lower Obesity in Chicago Children), and Community Organizing for Obesity Prevention in Humboldt

Park (CO-OP HP). These organizations compose part of the Humboldt Park community infrastructure needed to address diabetes.

1.3. ***Identify and train at least two Outreach Workers to conduct workshops and talk to individuals and groups about the impact of diabetes in the community.***
Outreach Workers should be recruited from the neighborhood, be bilingual, be effective communicators and display enthusiasm about the HPDP. In this phase of the project, the Outreach Workers will be responsible for disseminating information about the HPDP and making neighbors aware of efforts underway. In particular, they will prepare the community for the Screening Campaign (recommendation 2.0); beginning in the second year of the project, they will be actually conducting the screenings in the community.

1.4. ***Design and implement a Social Marketing Campaign to promote awareness and action on diabetes in Humboldt Park.***
Businesses use marketing to influence the behaviors of potential customers; social marketing has been described as the planning and implementation of programs designed to bring about social change using concepts from commercial marketing with the ultimate aim of influencing action. An organized campaign will further increase awareness of diabetes within the community by promoting the project via radio and television stations in both English and Spanish. Additional efforts could include a poster campaign, in stores, schools—school council parent meetings, churches, community centers, unemployment centers, as well as other centers such as WIC, YMCA etc. Business partners must be identified who will provide in-kind contribution of creative talent and grants will be pursued to develop effective materials and strategies for the social marketing campaign.

2. DEFINE THE SCOPE OF THE PROBLEM WITHIN THE COMMUNITY

Although the Sinai study indicates dramatic rates of individuals who are aware that they have diabetes, published national data indicate that there is also a substantial population of

undiagnosed diabetics. Using the widely quoted statistic of 33% undiagnosed, we estimate that if 20% of the adult Puerto Rican population of Humboldt Park already know that they have diabetes, there is another 10% (or approximately 2,000 people) with undiagnosed disease. A still larger number have "Pre-Diabetes" or Metabolic Syndrome, putting them at risk of diabetes. Early detection and action can avoid the damage to the body that can occur when people have uncontrolled diabetes.

2.1. ***Design and implement a community wide screening campaign for diagnosing persons with diabetes and also for those at risk of developing diabetes***

Over a two-year period, the HPDP will provide free screenings in a wide variety of settings to ensure the widest possible participation within the community. Examples of such settings include CBOs, churches, grocery stores, libraries, and other public places. In addition, the HPDP screening could be conducted by current project partners such as Rush University Medical Center, Erie Family Health Center, the Cook County Bureau of Health Services, the National Kidney Foundation of Illinois (through its KidneyMobile), the American Diabetes Association, St. Elizabeth Hospital, Norwegian-American Hospital, and the Access Community Health Network. By participating, these health partners would also agree to provide access to care to their respective health centers and hospitals for persons identified with diabetes that are in need of direct services. Screening should consist of simple health history, height/weight/ waist circumference / blood pressure measurement, and glucose measurement. These can be conducted in virtually any location at any time, without extensive preparation.

Community residents who are screened will receive immediate results and information about their personal risk for diabetes. Depending upon their risk, they will receive targeted culturally relevant health education materials. In addition, they will be encouraged to participate in education and early intervention programs, as described under recommendation 3.0.

2.2. ***Prepare an annual report to the community about findings of the Screening Campaign.***

It is essential that the information gathered by the Screening Campaign be returned to the community. HPDP will work with the Illinois Department of Public Health and the Chicago Department of Public Health to explore the creation of an annual community health report summarizing diabetes statistics about the community to allow monitoring health of the community and provide feedback to the community as a whole.

3. PRIMARY PREVENTION: REDUCE THE NUMBER OF PEOPLE WHO DEVELOP DIABETES IN THE COMMUNITY

3.1. ***Establish a Diabetes Community Education Center (DCEC) in Humboldt Park***

The Diabetes Community Education Center will be a visible sign of the commitment to addressing the problem of diabetes. Its placement in a prominent and accessible location will provide a center for education, screening, and self-management training. The DCEC can house the project as well as a wide range of educational programming to intervene with children and families at risk for the development of diabetes.

During the first year of the project, the DCEC should offer general programs on diabetes education as part of the awareness efforts (Recommendation 1.0). When the Screening Campaign is put into place (Recommendation 2.0), screenings can be conducted at this site as well. In subsequent years, the DCEC will provide more intensive education and follow-up for persons who have been identified as being at risk for developing diabetes and who seek to reduce their risk of progressing to the disease.

(Although not directly part of the primary prevention effort, the DCEC will also develop a role as a full service center for assisting persons diagnosed with diabetes, providing referral, self-management support, and intensive interventions to improve care. These efforts are described in Recommendations 4 and 5.)

3.2. ***Implement an intervention program for children identified as "at risk" through community screening programs***

CO-OP Humboldt Park, working in collaboration with CLOCC, has already begun efforts to identify and intervene with children at or before they enter elementary school. We recommend that these efforts be expanded, with the objective of reducing the rate of obesity by the time children enter high school.

All children identified as "at risk" due to elevated BMI measurements in community screening or because of family history will receive a referral to their physicians with information about the risk of diabetes and information about available lifestyle promotion programs. We will also work with after-school and other physical activity programs within the community to expand capacity and availability, to ensure that children have access to a range of safe and acceptable physical activities.

3.3. ***Design and implement multifaceted interventions aimed at diet, physical activity, and behavior change based in worksites and other settings in the community.***

The CDC's Guide to Community Preventive Services (6/30/2005) recommends such interventions for overweight and obese individuals because of evidence of cost effectiveness of such programs in reducing weight.

Pilot interventions to promote healthier lifestyles are already underway in Humboldt Park. Such projects should be funded to promote their expansion to include all at-risk members of the community.

Examples of interventions that provide affordable nutrition education, fresh food access, and activity opportunities for residents of all ages include: the PRCC-CO-OP Humboldt Park Market Basket program; the various Producemobile operations in Humboldt Park and the HomeGrown Farmers Market, all of which address local and affordable access to fresh produce; Bickerbikes, a program of Bickerdike Redevelopment Corporation; TASK (Travel that is Active and Safe for Kids);

Muevete, Girls in the Game and other physical activity available in Humboldt Park; peer education through the *Promotoras* program of Centro San Bonifacio; nutrition education through the EFNEP (Expanded Food and Nutrition Education Program)-University of Illinois Extension; and the Chicago Partnership for Health Promotion (CPHP).

Targeted efforts, including direct mail and personal contact by outreach workers will engage "at risk" adults and children to promote their participation in these programs. General information about these programs will also be disseminated through an informational campaign (Recommendation 1.4), and physicians' offices and clinics (Recommendation 4.2).

Any gaps left by currently available services will be identified through on-going evaluation, and the HPDP will work to fill these in collaboration with the Park District, Chicago Public Schools, YMCA, Illinois Extension Service, and others.

3.4. ***For persons with pre-diabetes, provide effective early intervention to reduce the risk of progressing to develop diabetes.***

The Diabetes Prevention Program (DPP), the DREAM study, and other research trials have effectively demonstrated that for persons at risk of developing diabetes, the use of medications or behavioral interventions can significantly reduce the rate of incident diabetes.

All persons identified with pre-diabetes will receive information about strategies to reduce their risk of progression to diabetes, as well as facilitated referrals to community services. Enhanced, culturally relevant lifestyle education programs will be developed in year 3 - 5 of the project, based at the Community Diabetes Education Center.

Most experts now recommend medication to reduce the rate of progression from pre-diabetes to diabetes in adults. For uninsured and under-insured individuals, a program to provide these medications (such as Metformin or Rosiglitazone) will be needed. HPDP will seek funding to ensure that all adults with pre-diabetes who are appropriate candidates for medication intervention and who wish to use such medications will have access to them.

4. IMPROVE MEDICAL CARE FOR PEOPLE WITH DIABETES

4.1. ***Engage health care providers serving Humboldt Park in a diabetes collaborative network to improve diabetes care.***

Across the US, collaborative provider networks have served to improve diabetes care. HPDP will bring together the "safety net" providers within the community (Cook County Bureau of Health Services, Erie Family Health Center, Access Community Health Network, Near North Health Services) along with community hospitals and academic health partners to address quality of care and access to services.

4.2. ***Develop and implement an intensive diabetes quality care education project for health care providers.***

4.3. ***Design and implement quality improvement projects across all of the members of the Humboldt Park diabetes collaborative network.***

The prevalence of diabetes requires management be carried out in the primary care settings. "Best practice" protocols have been shown to improve diabetes care. A program to reach all providers with on-going education and quality measures for follow-up is needed to enhance care on the front lines. This type of intensive provider education has had demonstrated benefit in the national Chronic Care Collaboration model; a local example has been the partnership of an academic medical center (Rush University Medical Center) with a community hospital (St. Anthony's Hospital) under the leadership of Dr. David Baldwin.

Working together with community partners in the HPDP, culturally-relevant, low literacy education and referral resources will be made available to providers to enhance care for newly identified persons with diabetes and at-risk adults and children.

Sharing of data among members of the collaborative network and publication of that data within the community will create a visible commitment to improving care of diabetes. Such data can include information about adherence to published practice guidelines and rates of diabetes control (as measured by readily available tests such as Hemoglobin A1c). This will identify opportunities for continued improvement in existing services, and sharing of "best practices" among members of the collaborative network.

4.4. ***Conduct an annual clinical needs assessment to ensure adequate health system resources***

We cannot simply improve diabetes awareness and diagnosis in the community without ensuring that the resources exist to treat these new cases. Safety net providers in Humboldt Park are already at – or past – capacity to deliver needed services to the current population of known persons with diabetes. As this project identifies up to 1,000 additional individuals with diabetes, as well as a significantly larger number with pre-diabetes, it is essential that the health system be monitored, and additional providers be sought to provide care.

We estimate that over the course of this project, an additional 2 to 3 primary care physicians and 3 full time nurse practitioners may be needed to meet demand. Hiring of these new providers would occur in a staged process over five years; state and federal funding should be sought to hire additional primary care providers within the diabetes collaborative network, as indicated by the annual needs assessment.

4.5. ***Implement diabetes clinical services at the Diabetes Community Education Center (DCEC)***

A freestanding diabetes care center with links to Cook County Bureau of Health Services, Erie Family Health Center, Access Community Health Network, Near North Health Services, and other primary care providers in the community would offer significant advantages:

- *Linking patient care to education and screening initiatives*
- *Adding the value of Certified Diabetes Educators and Community Health Workers to patient care – which is more difficult to implement if services are decentralized across multiple centers.*
- *Avoiding overwhelming any one provider with uncompensated care*
- *Focusing on diabetes creates environment for best quality of care*
- *Having a single source for diabetes specialty services within the community*
- *Having potential ability to control medication costs through bulk purchases, strict generic formulary*

Critical to the success of this approach is that community providers will be engaged in the development of the CDEC and kept informed of plans for its operation. Health care providers must see the CDEC as a resource and a benefit to them and their patients, and NOT as a threat. Providers must receive timely electronic reports of patient progress, medications, and educational interventions.

Resources needed to implement this program would include: Certified Diabetes Educators and Community Health Workers (Recommendation 5); social worker; and a pharmacist. A simple fingerstick A1c monitor should be available to provide patients with immediate feedback on their progress towards diabetes control.

One of the biggest challenges will likely be providing access to medications for the many uninsured and under-insured persons in the community. In addition to oral

medicines to control blood sugar, the prevention of complications for persons with diabetes also requires medicines to control blood pressure and cholesterol, as well as less costly medicine such as baby aspirin. In collaboration with the Cook County Bureau of Health Services, a formulary of generic medications with demonstrated benefit for preventing diabetes complications should be developed.

4.6. ***A case management program should be developed for all persons with diabetes in Humboldt Park***

The CDC's Guide to Community Preventive Services (1/17/2003) recommends disease management and case management services because of strong evidence of cost effectiveness. It is not uncommon for persons with chronic diseases such as diabetes to miss doctors appointments, run out of medicines, or forget to get needed tests. Case managers can help people with diabetes organize their care, get regular follow-up, and avoid falling through the cracks of the health care system. Five to six case managers will be needed for the estimated 1,000 new cases of diabetes to be identified, as well as for the people who have already been diagnosed but who are not receiving care on a regular basis. Case Managers will engage people by phone and will help them receive services through reminders, information, and referrals.

5. HELP PEOPLE WITH DIABETES TAKE BETTER CARE OF THEIR HEALTH

5.1. ***Implement a "diabetes information clearing house" within the DCEC to provide educational materials and referrals to community agencies***

Almost from its inception, the DCEC can begin to serve as a resource directory for persons with diabetes. Beyond providing a site for literature, video education, access to effective websites (such as that of the American Diabetes Association), the DCEC should maintain a directory of resources available in Humboldt Park to help persons with diabetes. In addition to health care providers, this would include exercise programs, food and nutrition services, social services, and CBOs. This recommendation can be rapidly implemented at relatively low cost.

5.2. ***Provide free diabetes self-management education and resources for people diagnosed with diabetes***

The CDC's Guide to Community Preventive Services (1/17/2003) recommends Self-Management education in community gathering places based on evidence of cost effectiveness. We recommend hiring three full time Spanish-speaking Certified Diabetes Educators to work in the CDEC and provide diabetes self-management classes and one-on-one counseling. In addition, up to six full time Spanish-speaking Community Health Workers (*promotoras*) should be hired to follow up with newly diagnosed diabetics in their homes and in community settings to ensure understanding and behavior changes.

Self-monitoring of blood sugar is recommended for all persons with diabetes, but it is absolutely essential to the approximately 30% of adults who must use insulin to control their sugar. The CDEC should provide free glucose meters and test strips to diabetics in the community who use insulin, and should provide the needed education to allow those individuals to use their meters effectively.

5.3. ***Provide community-based resources to healthy decision-making regarding nutrition and physical activity for persons with diabetes and their families.***

Persons living with diabetes must make dozens of decisions each day that will affect their illness – decisions about what to eat, whether to walk or drive, what physical activity to engage in, buying and taking their medicine, and many more. Simple interventions such as signs encouraging people to take the stairs rather than waiting for an elevator have been shown to improve rates of diabetes control in community settings. In addition, such supports benefit everyone in the community by promoting healthier lifestyle choices.

The HPDP will work with community leaders and businesses to implement such health-promoting resources. These efforts could include a voluntary nutrition labeling program at markets and restaurants in the community, or widely

disseminated flyers publicizing existing exercise programs at community centers, park district field houses, and senior centers.

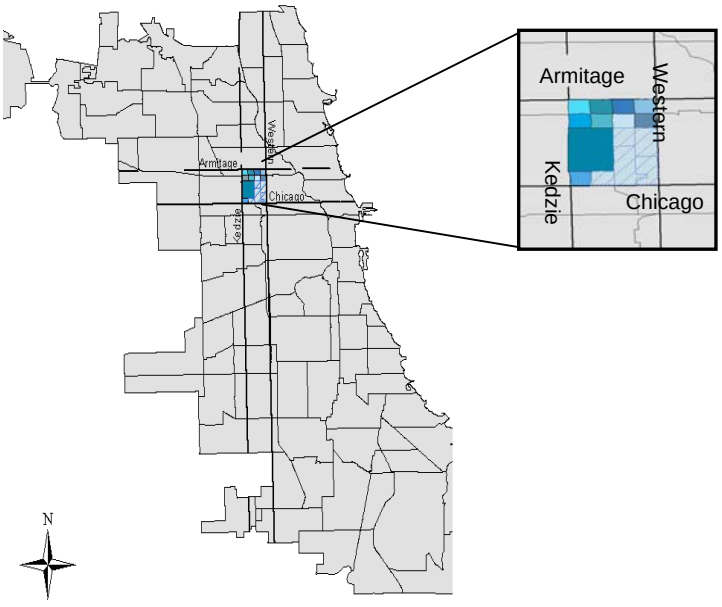
When needed resources do not currently exist in the community (for example, a lack of ready affordable fresh fruits and vegetables), the HPDP will work with community based organizations to help obtain them, or to develop them within the community.

PROJECT COMMUNITY

We would like to help everyone in Chicago and even the United States who has diabetes, or who might get diabetes. Since this is, of course, an impossible position to start with, we thought that it would be good to select a comparatively small, well-defined geographical area, run a "pilot project" there for five years, and carefully evaluate what happens. (We are particularly well suited for such an effort due to the remarkably varied talents of members of the Task Force.) If our efforts are successful, then we will argue with great energy that they be replicated throughout Chicago and even beyond. As the slogan for universal health care says, "Everybody In, Nobody Out." That is our eventual goal. Starting with this one small project area is our strategy.

We thus have decided to that we will use the geographic boundaries of Chicago Avenue (south) to Armitage Avenue (north), and Western Avenue (east) to Kedzie Avenue (West). This area is commonly known as Humboldt Park. Note that this overlaps with (but does not correspond exactly to) the officially designated community area of Humboldt Park.

MAP OF PROJECT COMMUNITY IN CHICAGO



The 2000 census counted 37,166 people in this area. Of these 33% were Puerto Rican, 27% were Mexican, 16% were White, 13% were Black and the rest were "Other," many of these "Hispanic other."

If we use the prevalence of (non-gestational) diabetes for each of these four groups, derived from our community study (and presented in the Sinai Urban Health Institute

paper cited above), and apply these to the number of people 18+, then we wind up with an estimate of 2,469 people in the project area who have been given a diagnosis of diabetes. The literature suggests that one third of people with diabetes have not been given a diagnosis. This implies that 1,235 such people also live in the project area. Thus, altogether we estimate that 3,704 people 18+ in the project area have diabetes.

HUMBOLDT PARK DIABETES PROJECT TIMETABLE

YEAR	Qtr	Operations	Awareness	Screening	Prevention	Healthcare	Self care
1	1	Hire Staff, Establish office Recruit HPDP partners (Public and private sectors, health care, business)	1.1 Oversight Board 1.2 Commnty Mtgs; Engage CBOs 1.3 Outreach Wkrs Publicize screening campaign	2.1 Design Screening Campaign	3.1 Establish Diabetes Commun Ed Cntr DCEC 3.2 Childhood Intervention Program	4.1 Create Diabetes Collaborative network 4.2 Educational & Referral Resources	5.1 DCEC serves as information clearing house / referral ctr
	2						
	3						
	4						
2	1		1.4 Implement Social Marketing Campaign	2.1 Implement Screening Campaign	3.3 Multifaceted workplace and community interventions	4.3 Shared data on quality of care 4.4 Needs assessment	5.2 Self-management education programs (CDEs, Community Health Workers)
	2						
	3						
	4						
3	1				3.4 Intervene with "Pre-Diabetes" group	4.5 Clinical services @ DCEC 4.6 Case Management	5.3 Community-wide campaign of support for healthful decision making
	2						
	3						
	4						
4	1			Complete 2 year Screening Campaign			
	2						
	3						
	4		Annual Reports to Community about Progress of the HPDP		Evaluation of All Interventions and Continuous Quality Improvement		
5	1						
	2						
	3						
	4						
OUTCOME			Over 90% of surveyed residents of HP will be aware of the impact of DM in their community, and the work of the HPDP.	Residents will be aware of their own risk of diabetes or that they have the diagnosis. Over 1,000 new cases of DM will be identified.	Persons at risk of developing diabetes will have ready access to culturally relevant education & intervention programs designed to reduce their risk	Persons with diabetes will have improved quality of care, and will have measurable improvement in the control of their disease..	Persons with diabetes will know what they need to do to manage their diabetes and will have ready access to the tools needed to help them manage their disease.
		REDUCE THE ADVERSE IMPACT OF DIABETES ON THE RESIDENTS OF HUMBOLDT PARK REDUCE THE RATE OF DIABETES-RELATED HOSPTIALIZATIONS AND COMPLICATIONS WITHIN FIVE YEARS					

CONCLUSION

Over the next five years, hundreds of people with diabetes in Humboldt Park will suffer potentially avoidable blindness, kidney failure and dialysis, heart attacks, strokes, amputations and other complications; dozens will be killed by the disease. The evidence is clear that diabetes and its complications are taking a disproportionate toll on this community.

The community residents, activists, and health professionals who have come together to prepare this report refuse to accept this as just another unfortunate set of statistics. This document contains recommendations for fighting diabetes in a Chicago community that is being devastated by the disease. The 19 recommendations listed have been assembled based on the best informed evidence that we could locate and that we believe can be practically implemented in Humboldt Park over the next five years. If successful in reducing the adverse impact of diabetes, we will have helped not only this neighborhood but also established an effective community model to be implemented elsewhere in Chicago and the nation.

- We call upon political leaders at the city, county, state, and federal level to recognize the magnitude of the problem and work to ensure funding for these efforts;
- We call upon the philanthropic community to provide additional support for the development of innovative new programs to reduce the impact of diabetes in this neighborhood;
- We call upon public health authorities to focus attention and resources on this problem;
- We call upon academic health centers and universities in our area to provide needed technical support and clinical services;
- We call upon the hospitals, clinics, and doctors in this community to work together to improve care for everyone with diabetes or who is at risk;

- We call upon the media to increase awareness of diabetes, and to help get the message out to the community that diabetes is not inevitable nor are its complications unavoidable;

- We call upon community organizations, religious institutions, businesses, and other agencies in Humboldt Park to consider how they can help in the fight against diabetes;

- We call upon residents of Humboldt Park to join with us to address the challenge of diabetes, and to hold all of us accountable for taking action to solve this problem.

WE HAVE A PLAN. THE TIME FOR ACTION IS NOW.