

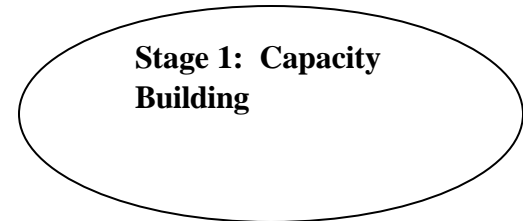
**Project Framework: CSCDAC REACH 2010 Project**  
**14 February 2004**

**Mission** *[What we do]*

- The Mission of CSCDAC Coalition is to reduce diabetes disparities and enhance the quality of life for Latinos and African-Americans living with or at risk for diabetes in Chicago’s southeast side communities through diabetes management, education, and systems change.

**Goals** *[What we want to achieve]*

**Goal #1:** Increase the capacity of coalition members to mobilize resources to reduce diabetes disparities.



**Target Audience:** Coalition Members and Target Community Activists

<b>Strategies</b> <i>[How we are going to get there]</i>	<b>Tactics</b> <i>[Initiatives and Activities]</i>	<b>Indicators</b> <i>[Specific, measurable outcomes]</i>
1. Build an effective diabetes <b>community coalition</b> composed of community residents, people living with diabetes, health and human services providers, and community leaders.	<ul style="list-style-type: none"> <li>✓ Contract with community-based healthcare and social service providers to assist in diabetes prevention and treatment</li> <li>✓ Ensure that partners are actively engaged in the work of the Coalition:               <ul style="list-style-type: none"> <li>○ Do outreach to local churches</li> <li>○ Recruit additional membership and partners</li> <li>○ Hold regular meetings of the Coalition in the target communities</li> <li>○ Establish Committees that will</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Increase in the number of coalition members</li> <li>● Attendance levels at coalition meetings</li> <li>● Coalition members complete tasks stipulated in contracts</li> <li>● Coalition is rated as effective (75% or higher) by Coalition members</li> <li>● Coalition Committees Implement their Action Plans</li> <li>● There are increased resources/ capacity in the community to address diabetes as</li> </ul>

	<p>implement action plans addressing specific areas: Provider/ Quality of Care, Community Education, Evaluation, Media/ Public Communication</p> <ul style="list-style-type: none"> <li>✓ Inform Coalition partners about potential sources of additional funding</li> <li>✓ Coordinate and assist in proposal writing to obtain additional funding or resources</li> <li>✓ Provide training on proposal writing, budgeting, etc.</li> </ul>	<p>measured by new grants, new programs, etc.</p> <ul style="list-style-type: none"> <li>• Coalition member organizations report improvements/ progress in their agency's capacity to provide information/ advocacy/ services to people living with diabetes.</li> </ul>
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**Goal #2: Promote the highest quality of diabetes care** through the implementation of ADA guidelines for diabetes treatment.

**Stage 3: Community and Systems Change; Change among Change Agents**

**Target Audiences:** Coalition member hospitals and participating providers

<b>Strategies</b> <i>[How we are going to get there]</i>	<b>Tactics</b> <i>[Initiatives and Activities]</i>	<b>Indicators</b> <i>[Specific, measurable outcomes]</i>
<p>2. Improve the <b>quality of diabetes treatment</b> and reduce barriers to access through provider involvement, training, and peer education</p>	<ul style="list-style-type: none"> <li>✓ ‘Train the trainers’: train providers to do peer education around cultural competence and CLAS guidelines and ADA Standards of Care</li> <li>✓ Identify comprehensive resources for holistic care of people living with diabetes</li> <li>✓ Regularly disseminate information to providers on CLAS and ADA Standards of Care (updates, etc.)</li> <li>✓ Adopt a common database to track diabetes status and interventions (SECAT)</li> <li>✓ Train providers and CSDCAC staff on SECAT data collection and management</li> <li>✓ Develop mechanisms to fund SECAT data entry</li> <li>✓ Develop a checklist of ADA guidelines for patient charts</li> </ul>	<p><u>Member Hospitals:</u></p> <ul style="list-style-type: none"> <li>• Hospitals receive update information on CLAS and ADA</li> <li>• SECAT is utilized by member hospitals</li> <li>• Data from Provider Questionnaire</li> <li>• # of provider education sessions</li> <li>• # of providers attending education sessions</li> <li>• Evidence of policy changes in member hospitals</li> <li>• Adherence to CLAS guidelines as explored in interviews with member hospitals</li> </ul> <p><u>Community Impact</u></p> <ul style="list-style-type: none"> <li>• Trend data from the Behavioral Risk Factor Survey in the target communities (2000 vs. 2004) [NORC database]</li> <li>• Trend data from the Illinois Foundation for Quality Assurance on Medicare/ Medicaid patients in the target communities (2000 vs. 2004)</li> </ul>

**Goal #3: Increase access** to diabetes related health and social services through reducing financial, cultural, linguistic and logistical barriers

**Stage 2: Targeted Action**  
**Stage 3: Community and Systems Change**

**Target Audience:** Community Providers and SCC clients

<b>Strategies</b> <i>[How we are going to get there]</i>	<b>Tactics</b> <i>[Initiatives and Activities]</i>	<b>Indicators</b> <i>[Specific, measurable outcomes]</i>
<p>3a. Use community-based <b>Self-Care Centers</b> to provide outreach, referral, case management, and social support to people living with or at risk for diabetes.</p> <p>3b. Evaluate the best model to get people into self-management education.</p>	<ul style="list-style-type: none"> <li>✓ Work with community health care providers on policy changes to increase access (Policy Committee)</li> <li>✓ Develop formal referral agreements</li> <li>✓ Train SCC and member organization staff on skills to identify and access resources (Carol Goldbaum)</li> <li>✓ Ensure that every client is linked to a healthcare provider</li> <li>✓ Recruit and train community residents as community health workers/ peer educators</li> <li>✓ Recruit clients/ community youth to be active participants/ volunteers in center and outreach activities</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of the Policy Committee Work Plan</li> <li>• % of SCC clients with a regular source of care</li> <li>• # of community volunteers working with self care centers</li> <li>• Self-report data on access from Access to Care Questionnaire</li> </ul>

**Goal #4: Identify untreated diabetes and reduce diabetes complications, disabilities, hospitalizations, and mortality**

**Stage 2: Targeted Action**

**Target Audience:** People living with, or at high risk for, diabetes participating in SCC programs

<b>Strategies</b> <i>[How we are going to get there]</i>	<b>Tactics</b> <i>[Initiatives and Activities]</i>	<b>Indicators</b> <i>[Specific, measurable outcomes]</i>
<p>4. Educate people with diabetes in <b>self-care management skills</b>.</p>	<ul style="list-style-type: none"> <li>✓ Conduct intensive, 10 week DEEP training several times/ year</li> <li>✓ Promote exercise</li> <li>✓ Involve family members of people living with diabetes in training and center activities</li> <li>✓ Promote weight loss competitions</li> <li>✓ Distribute recipes</li> <li>✓ On-going Diabetes Support Groups, Walking Clubs, etc.</li> </ul>	<p><u>SCC Clients:</u></p> <ul style="list-style-type: none"> <li>• % of clients who report eating at least three servings of fruits and vegetables per day</li> <li>• % of clients engaged in at least 30 minutes of vigorous physical activity at least 5 times a week</li> <li>• % of clients who check their blood glucose levels at least once a day</li> <li>• % of clients who have an eye examination at least twice a year</li> <li>• % of clients who have an A1C exam at least twice a year</li> <li>• % of clients who have a foot examination once a year</li> <li>• # of clients participating in walking clubs</li> <li>• # of client family members engaged in self care center activities</li> <li>• # of clients participating in support groups</li> <li>• Reduction in number of hospitalizations among clients</li> <li>• Scores on <i>Diabetes Knowledge Questionnaire</i> Pre and Post</li> </ul>

<p>5. Conduct <b>outreach and screening activities</b> to identify and intervene in undiagnosed diabetes.</p>	<ul style="list-style-type: none"> <li>✓ Conduct and participate in community Health Fairs or screening efforts</li> <li>✓ Conduct training with community residents on diabetes control (e.g. "Diabetes Today")</li> <li>✓ Conduct outreach to community organizations (e.g. park district and churches)</li> <li>✓ Screen people to identify people living with or at risk of diabetes</li> </ul>	<ul style="list-style-type: none"> <li>· # of previously undiagnosed people with diabetes identified</li> <li>· # of previously undiagnosed people successfully referred for services</li> </ul>
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**Goal #5: Increase community awareness** about diabetes risk and prevention factors.

**Stage 3: Change among Change Agents**

**Target Audiences:** Community residents and business owners

<b>Strategies</b> <i>[How we are going to get there]</i>	<b>Tactics</b> <i>[Initiatives and Activities]</i>	<b>Indicators</b> <i>[Specific, measurable outcomes]</i>
6. Increase community awareness of risk factors through saturating the communities with highly visible, bilingual <b>public information</b> on diabetes.	<ul style="list-style-type: none"> <li>✓ Display visible information about diabetes (e.g. Diabetes posters, bumper stickers, bus CTA ads, etc.)</li> <li>✓ Publish a bilingual Coalition news letter</li> <li>✓ Establish a Coalition website</li> <li>✓ Develop a diabetes PSA for radio use</li> <li>✓ Promote an educational website</li> <li>✓ Use cable show to promote coalition activities</li> </ul>	<p><u>Community residents:</u></p> <ul style="list-style-type: none"> <li>• Report from NORC community survey</li> </ul>
7. Conduct <b>outreach to community businesses</b> to adopt policies and practices which promote healthy eating and lifestyles.	<ul style="list-style-type: none"> <li>✓ Provide incentives to businesses to change their stocking practices</li> <li>✓ Meet with owners of food stores and restaurants to educate them about diabetes and encourage them to change stocking practices or menus</li> <li>✓ Establish relationships with Chambers of Commerce in target communities.</li> <li>✓ Utilize seal of approval stickers to reward restaurants and stores that change practices</li> <li>✓ Provide pamphlets to stores and restaurants</li> <li>✓ Set up information tables at restaurants</li> <li>✓ Replicate the model used by the South Chicago Chamber of Commerce</li> </ul>	<p><u>Business Owners:</u></p> <p>Data from the <i>Community Business Addendum Survey</i> and <i>Chamber of Commerce/ Healthy South Chicago</i> Evaluation Reports:</p> <ul style="list-style-type: none"> <li>• # of posters visibly displayed in community stores and businesses</li> <li>• # of businesses in the community which have changed their stocking or menu in response to Coalition efforts</li> <li>• Change in quantity of fruits and vegetables sold in targeted stores</li> <li>• The Coalition is actively engaged with the Chambers of Commerce in all target</li> </ul>

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