Funding provided by the CDC’s National Program to Eliminate Diabetes-Related Health Disparities in Vulnerable Populations
Executive Summary

The National Kidney Foundation of Michigan and its leadership partners, the Michigan Diabetes Prevention and Control Program (DPCP) at the Michigan Department of Community Health (MDCH) and the University of Michigan Center for Managing Chronic Disease (UMCMCD), have a long history of working towards reducing health disparities in vulnerable populations. This project, Program to Eliminate Diabetes-Related Health Disparities in African American adults living in Flint, NW Detroit, and Inkster, Michigan, has spent the last year building capacity in the form of community coalitions in each of the communities. Each coalition has completed a community needs assessment and developed a strategic plan to address the needs of each community by capitalizing on the partnerships and existing infrastructure that are presently underutilized in these vulnerable communities. The strategic plan provides rationale and objectives to promote good nutrition, increase opportunities for low-cost, safe physical activity, promote chronic disease management, share information related to diabetes support and management, and stimulate policy change at the organizational, local, and state levels. This plan will be re-evaluated and updated on an annual basis to ensure that the objectives continue to meet the needs of African American adults with diabetes living in Flint, NW Detroit, and Inkster, Michigan.

Background & Need

The National Kidney Foundation of Michigan (NKFM), a community-based non-profit organization, has a long history of working to make health equity a reality. The NKFM has a rich history of working with its two key leadership partners, the state DPCP and the UMCMCD, in addressing diabetes health-related disparities in minority populations. For over a decade, reducing health disparities has been a focus of these collaborators, bringing together key strengths and expertise to address the formidable challenges of planning, implementing and evaluating innovative community-based interventions in vulnerable populations. Over the past 16 years, NKFM and MDCH programs have linked multiple community-based strategies and organizations together to address the interactive nature of environmental- and community-level factors influencing health in poor, low-income, and underserved populations. When developing community coalitions, NKFM
promotes coordination and collaboration with community partners to build relationships and trust, enabling the pooling of resources, expertise and talent, and fostering synergies that benefit all involved parties. A key lesson learned through implementing community-based programs is that collaboration is critical to address the many challenges in the social, cultural, and physical environment that conspire against change and achieving health equity.

**Focus Population**

Prior to the initiation of the CDC *National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations* project, NKFM had a significant presence in Flint, NW Detroit, and Inkster. All three communities have large African American populations, markedly higher than average rates of diabetes, and multiple negative social health determinants, including low socioeconomic status, high unemployment rates, low education levels, high crime rates, etc. These underlying root causes were among the reasons NKFM selected these three communities as the focus for the *Vulnerable Populations* project. The vulnerable population addressed by the project is African American adults living with diabetes. Each community has sufficient political, social, and health system infrastructure in place to ensure a measurable impact.

The death rate for people with diabetes in Michigan is 26.8 per 100,000 and 41.1 per 100,000 for African Americans. African Americans, both male and female, have higher rates of diabetes than Whites. Health disparities do not exist or develop randomly. They are the product of a host of factors that affect individuals from their birth to their death.

*Table 1. Demographics.*

<table>
<thead>
<tr>
<th>Location</th>
<th>% African American</th>
<th>% 65+</th>
<th>% Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>14.2</td>
<td>12.3</td>
<td>18.7</td>
</tr>
<tr>
<td>Flint</td>
<td>65.4</td>
<td>10.7</td>
<td>27.1</td>
</tr>
<tr>
<td>NW Detroit</td>
<td>92.0</td>
<td>10.5</td>
<td>26.6</td>
</tr>
<tr>
<td>Inkster</td>
<td>67.5</td>
<td>10.8</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Statewide and local government agencies, academic institutions, and community organizations recognize the need to confront the socioeconomic circumstances in which people in Flint, Inkster, and NW Detroit...
work and play to improve their health and well-being. Income, cost of living, local school characteristics, civic participation, air and water quality, physical safety, and tobacco use are some of the 180 social determinants of health (SDOH) that are included in the Data Set Directory of Social Determinants of Health at the Local Level. Poverty and low socioeconomic status are two significant predictors of adverse health outcomes.

### Table 2. Evidence of Burden of Diabetes.

<table>
<thead>
<tr>
<th>Location</th>
<th>% individuals with diabetes</th>
<th>Est. # of people with diabetes (target population)</th>
<th>% Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>8.5</td>
<td>646,700</td>
<td>12.4</td>
</tr>
<tr>
<td>Flint</td>
<td>&gt; 14</td>
<td>2,760</td>
<td>7.6</td>
</tr>
<tr>
<td>NW Detroit</td>
<td>&gt; 14</td>
<td>15,562</td>
<td>38.1</td>
</tr>
<tr>
<td>Inkster</td>
<td>&gt; 11</td>
<td>2,422</td>
<td>27.7</td>
</tr>
</tbody>
</table>

Further exacerbating health disparities, is the 16.3% unemployment rate for Flint. Fear of crime and limited access to fresh fruits and vegetables negatively impact overall health status for Flint residents, particularly in the area of diabetes prevention and management. In 2007, only 39.8% of Flint residents indicated that it was fairly or completely safe walking alone in their neighborhood after dark. Overall 13.8% of Flint residents say that they have some or a lot of difficulty getting to a grocery store or supermarket that has a good variety of fresh fruits and vegetables.

### Table 3. Social Determinants of Health.

<table>
<thead>
<tr>
<th>Location</th>
<th>% Below Poverty Level</th>
<th>Education, % high school graduate / % Bachelor's degree or higher</th>
<th>% Inadequate Physical Activity Adults/Youth</th>
<th>% Inadequate Fruit and Vegetable Consumption</th>
<th>% Fast Food Consumed Two or More Times per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>10.5</td>
<td>83.4 / 21.8</td>
<td>49.4 / 62.0</td>
<td>78.3</td>
<td>24.9</td>
</tr>
<tr>
<td>Flint</td>
<td>35.7</td>
<td>65.3 / 4.9</td>
<td>53.2 / *</td>
<td>82.1 *</td>
<td>*</td>
</tr>
<tr>
<td>Inkster</td>
<td>19.5</td>
<td>74.3 / 12.1</td>
<td>50.4 / *</td>
<td>77.7 **</td>
<td>*</td>
</tr>
<tr>
<td>NW Detroit</td>
<td>13.9</td>
<td>77.1 / 14.1</td>
<td>56.7 / *</td>
<td>77.2 **</td>
<td>*</td>
</tr>
</tbody>
</table>

*Data not available **County data where city is located

As of October 2009, the unemployment rate in Inkster was 19.8%. Inkster schools experience serious challenges meeting State and National standards from Elementary through High School. The 2007-2008 school year saw a staggering dropout rate of 49%. In 2007, Inkster reported a crime rate of 40.13 per 1,000 residents for property crimes, and 13.42 per 1,000 for violent crimes (compared to national figures of 32 per 1,000 for property crimes and 5 per 1,000 for violent crime).

Northwest Detroit is considered an urban food desert, where finding fresh fruits and vegetables or even grocery stores that provide healthy choices are extremely limited. Lack of transportation in Detroit is a major contributing factor to urban food deserts. As a result, the area has struggled with epidemic-level
obesity rates and disproportionate rates of chronic diseases, including diabetes. Additionally, Detroit had the sixth highest number of violent crimes among the twenty-five largest US cities in 2007. Moreover, the area has a crime rate of 62.18 per 1,000 residents for property crimes, and 16.73 per 1,000 for violent crimes.

**Community Coalitions**

NKFM has leveraged local partnerships in Flint, NW Detroit, and Inkster to form a coalition in each community consisting of representatives from minority-based organizations, partnering businesses, community agencies, groups, local government, education institutions, housing developments, and other stakeholders. Each coalition has a local steering committee (LSC) that provides oversight to the coalition and consists of the “movers and shakers” of the coalition. While the coalition is open to anyone within the community, the LSC consists of those individuals and partners who are willing to contribute to the success of the project.

**Flint:** The city of Flint resides in Genesee County, the fifth most populous county in Michigan (MI). Flint comprises 24% of the County’s population and is the largest city in the County. 52.5% of Flint residents are African American and more than 14% of Flint residents have diabetes. Coalition meetings began in November 2010. As many as 60 persons have attended coalition meetings but the actual number of persons committed to the self-named *Flint – Better Health Together* (FBHT) coalition is approximately 25. The FBHT coalition is comprised representatives from:

- Health plans
- Food advocate
- Nutrition educator
- County Health Department
- County Health Plan
- Intermediate School District
- Public Library
- Health systems
- City representative
- Fitness Foundation
- Dialysis provider
- Worksite Wellness
- Secondary Education (colleges)
- Faith based organizations
- Pharmaceutical organizations
- Diabetes education
- Community Mental Health
- Community development
- Neighborhood block club representatives
- Federally Qualified Health Center
- Community members
- Area Agency on Aging
- Other community health coalitions

As the diverse community stakeholders became organized, the coalition defined their commitment to each other to influence social determinants of health. FBHT partners created a mission statement: “Promoting
healthy living and positive choices to decrease the unequal impact of diabetes in our community”, and their hope for the future is reflected in their vision statement: Flint is a socially responsible community where the root causes of health inequity are addressed.

**Northwest Detroit**: NW Detroit is located in Wayne County. With a population of approximately 2.1 million, it is the most populous county in MI and the thirteenth most populous county in the Nation. Detroit’s population is 82.7% African American and 14% of residents have diabetes. Coalition meetings began in November 2010. As many as 60 persons have attended coalition meetings, with the actual number of persons committed to the self-named Detroit – Community Against Diabetes (DCAD) coalition being approximately 20. The DCAD coalition is comprised representatives from:

- Health plans
- Food advocate
- Nutrition educator
- Farmers Market
- Food bank
- Institute of Multicultural Health
- City Health Department
- Local Area Agency on Aging
- City Parks and Recreation
- Health systems
- City representative
- Community Center
- Secondary Education (university)
- Faith based organizations
- Local restaurants
- Pharmaceutical organizations
- Diabetes education
- Community Mental Health
- Community development
- Federally Qualified Health Center
- Free health clinic
- Community members
- Other community health coalitions and local businesses

Initial DCAD meetings were dedicated to building relationships and providing education about SDOH and health disparities. The DCAD partners created a mission statement: “To promote health equity in Detroit through policy-making, environmental changes, community awareness, and action by developing resources through strategic collaboration,” and their vision for the future is reflected in their vision statement: Health, Equity, Access, Learning, and Empowerment in Detroit (HEALED).

**Inkster**: Inkster is a small community, six square miles, in Wayne County. The Inkster population is 61.3% African American and diabetes is very prevalent (>12%). Inkster also experiences high unemployment, as well as high rates of crime and violence. In May 2010, Inkster Partnership for a Healthier Community (IPHC) was born out of a small capacity building grant from the Michigan Department of Community Health (MDCH) to address factors that influence health disparities in this predominantly African American community. As over 40 diverse community stakeholders became
organized, IPHC defined their commitment to each other to influence SDOH. The IPHC is comprised of representatives from:

- Inkster city officials and policy-makers
- Inkster Public Schools
- City of Inkster police department
- Hospital
- Businesses
- Faith-based organizations
- Literacy Agency
- Housing development
- Neighboring hospital (there are no hospitals in Inkster)
- Food Bank
- Parks and Recreation Department
- Federally Qualified Health Center
- Block Clubs
- Human Development Corporation
- Library
- Chamber of Commerce
- NAACP
- County Health Department
- YWCA
- Family Health Center
- Greek letter alumnae organizations
- Other community-based organizations and community members

IPHC partners created a mission statement: “to improve and develop safe, healthy, and educated neighborhoods through community action and resources”, and their hope for the future is reflected in their vision statement: Inkster - Healthy, Equal, And Living (I-HEAL).

**Community Needs Assessments**

NKFM collected relevant information on social, economic, and community conditions, health trends of the priority population, its risk status, and the impact of community environment on health. Sources of data include publicly available health statistics, focus groups, photovoice, surveys, key informant interviews, and a needs assessment using the CDC’s Community Health Assessment and Group Evaluation (CHANGE) Tool to identify the assets and specific needs of people living in Flint, NW Detroit, and Inkster. The CHANGE Tool was selected as the primary method of garnering information because of its specific focus on assessing the policy and environment setting in each community. The CHANGE Tool is a relatively sophisticated tool which made it difficult to administer, initially. As the coalitions better understood the tool and NKFM staff members were able to develop supplementary questionnaires to take in the field, the needs assessment process flourished. The needs assessment process has engaged the members of the coalitions and LSCs in the process of information-gathering but it has also been a strong component of our overall community organizing strategy. By assessing community needs, the coalitions have a meaningful voice to influence program design and create real change in their
community. The CHANGE Tool and other sources of data have provided the necessary depth of information to prepare an appropriate community strategic plan to address diabetes-related health disparities.

As evidenced by the findings of the community needs assessment conducted during Year 1, Flint, NW Detroit, and Inkster residents face a seemingly insurmountable array of social disadvantages and gender-based inequities. These challenges are exacerbated by race, with 65-95% of residents being African American. Black, non-Hispanic men and women fare significantly worse than Whites in many health measures.

**Strategic Plan**

Baseline information used to assess community health concerns was derived from results of the community needs assessments and publicly available health data. The priorities were established by Strategic Planning Workgroups established in each of the three coalitions. Workgroups, which consisted of the program manager, community coordinators, evaluators, and coalition members, conducted a series of planning sessions to review community data, identify strategies for addressing the priority areas of need, and formulate key program strategies. The workgroups discussed what could be done about the diabetes-related health inequities and what interventions might work to bring about change and what their expected effectiveness could be. In August 2011, the project’s Advisory Council and Leadership Team reviewed the recommendations from each community coalition, provided further insight, and assisted with the development of the SMART objectives detailed in this strategic plan. The Leadership Team emphasized that the actions to tackle diabetes-related health disparities need to be inter-related and address all levels of the socio-ecological model.

The interventions consist of evidence-based, culturally-acceptable programs serving adults living with diabetes in predominantly African American communities. Diabetes and its related complications are among these communities’ leading health concerns. The strategic plan contains community-based, culturally responsive, and evidence-based interventions aimed at improving health in African American adults living with diabetes. From a socio-ecological
intervention perspective, diverse resources and supports are needed to effectively manage the disease, including
(1) the positive and multiplier effects of education and health literacy for addressing challenges that may interfere with individual health decisions, (2) offering health education with ongoing follow-up and support across social and traditional media networks, (3) access to community resources and activities (e.g., regular physical activity and healthy nutrition), and (4) access to appropriate, high-quality treatment and continuity of care. This is a multi-component, intensive approach that will add value by strengthening and enhancing existing partnerships and networks that are a source of motivation and support for healthy behavior choices.

**Nutrition.** Nutrition goes beyond consuming food to fuel our bodies and concerns our health care system and overall wellbeing. Over the last two decades, obesity has emerged as one of the most common preventable illnesses. Obesity is particularly prevalent in Detroit. As of 2007, Detroit was ranked as the fifth most obese city in the country with 37.8% of the population overweight. Efforts to address diabetes-related health disparities require our acknowledgement that food quantity does not mean food quality. Many people consume high-calorie, low-nutrition foods. The average American consumes almost 1,000 more calories per day than in the 1950s, and many of those calories now come from refined grains, sugars and fats, and away-from-home meals. This coincides with lifestyle changes characterized by lower levels of physical activity. The result is a public health crisis that falls disproportionately on those unable to access healthy, affordable food. Minority populations are more likely to suffer or die from a diet-related disease such as type 2 diabetes or heart disease, holding other key factors constant. Although a poor diet is often attributed to personal choice, the lack of access to nutritious options in their neighborhoods creates a disadvantage for these communities.

Residents of many urban minority communities have limited access to healthy foods, particularly fresh produce, and the food deserts of Flint, NW Detroit, and Inkster are no exception. The preference for unhealthy foods has historical and social basis that pivots around the high cost and lack of availability of healthy foods. This situation contributes to the prevalence of obesity, high blood pressure and diabetes in local communities. The economic climate and environmental pressures of vulnerable populations encourages choices indicating low systemic support, limited options, and the anxiety of marginalization. Broad-based interventions are necessary to encourage and nurture a sense of community that supports healthy eating. The implementation and rise of community gardens and the current educational activities of community organizations provides the backdrop for supporting and linking activities that would provide enhanced food choices and community support as a foundation for healthy eating. Participation
on the local Food Policy Council is a means of providing a broader community connection and collaborative support for legislative lobbying and broad-based change and nurturing. Better availability of healthy food within the existing environment will enable communities to take action to reduce the adverse health outcomes associated with poor diet. The variety, price, and availability of healthy foods in the local environment can play a role in whether those foods are consumed.

In addition, providing diabetes-specific nutrition education will improve the health and well-being of participants by developing and promoting dietary guidance that links scientific research to the nutrition needs of adults with diabetes. Programs such as Cooking Matters, NuVal, and Shopping Matters, which all help families make healthy and affordable choices when meal planning and buying groceries. Cooking Matters and Shopping Matters can be tailored to provide diabetes-specific information, as well as provide guidance for shopping healthy and affordably in corner stores. The coalition partnerships will strengthen healthy food systems (e.g., expand community gardens, urban agriculture, social support for healthier diet) and reduce barriers (e.g., improve availability of affordable fresh produce in local stores) to healthy food options. Each community discovered a strong need to make fresh, healthy food more readily accessible by increasing the availability of healthy food products, reducing exposure to unhealthy food products, working with businesses to provide fresh produce in the community, and enhancing the environment to support healthy eating that will reduce the risk of type 2 diabetes.

<table>
<thead>
<tr>
<th>Year Two Objectives to Promote Good Nutrition</th>
<th>Measured By</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2012, develop and provide at least 2 diabetes-specific nutrition education sessions to African American adults with diabetes at community garden sites in Flint.</td>
<td>Number of people who received diabetes information</td>
<td>Garden Coordinator Self Report</td>
</tr>
<tr>
<td>By August 31, 2012, collect letters of support from at least 3 food providers in each community to demonstrate a commitment to increasing access to and consumption of healthy foods through the existing built environment (community gardens, food pantries, corner stores, etc).</td>
<td>Volume of produce given to low income residents; letters of commitment from pantries, corner stores, etc.</td>
<td>Wayne Metro; Garden reports; letters of commitment</td>
</tr>
</tbody>
</table>
By August 31, 2012, at least 6 Flint, 3 Inkster, and 3 NW Detroit healthy food shopping and/or preparation education programs (e.g. Cooking Matters, NuVal, Shopping Matters) will be provided to African American adults with diabetes.

By August 31, 2012, conduct a pilot project Flint corner store makeover with the aim of seeking policy and/or environmental change for African American adults with diabetes.

By August 31, 2012, at least 1 NW Detroit and 1 Inkster area restaurant will offer diabetes-friendly healthy menu options.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measured By</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2015, the Genesee County Health Department will expand their annual restaurant awards to include acknowledgement of diabetes-friendly menus.</td>
<td>Awards given for diabetes-friendly menus</td>
<td>Health Department</td>
</tr>
<tr>
<td>By August 31, 2015, develop a NW Detroit network of at least 10 corner stores committed to selling fresh healthy food.</td>
<td>Number of stores in network; written commitment received</td>
<td>Partner sites</td>
</tr>
<tr>
<td>By August 31, 2015, at least 4 NW Detroit restaurants will offer diabetes-friendly healthy menu options.</td>
<td>Number of restaurants offering diabetes-friendly menus</td>
<td>Partner sites, Menus</td>
</tr>
<tr>
<td>By August 31, 2015, develop an Inkster network of at least 3 corner/party stores committed to selling fresh healthy food.</td>
<td>Number of stores in network; written commitment from stores</td>
<td>Partner sites, Photovoice</td>
</tr>
</tbody>
</table>

**Physical Activity.** Overweight/obesity is a leading cause of diabetes, and African Americans have significantly higher rates of obesity (39.8% vs. 28.8%) when compared to their White counterparts. Obesity carries a higher risk of developing type 2 diabetes, as does being African American. Obese adults report the highest prevalence of poor life satisfaction, poor general health, poor physical health, poor mental health, and activity limitations compared to non-obese adults. In 2008, over half of adults (average 53%) in Flint, NW Detroit, and Inkster did not get the recommended amount of physical activity. Physical inactivity increases with age and decreases with education and income. Regular physical activity is one of the most important contributors to health and a key factor in maintaining a healthy weight. Physical inactivity is one of the modifiable risk factors for diabetes and is strongly correlated with...
increasing risk factors for obesity and diabetes. This project will focus program efforts on the communities and populations of greatest need. Research has shown that lifestyle changes that include physical activity can prevent chronic diseases and delay complications.

All three community needs assessments pointed to a need for opportunities for low-cost and safe physical activity. NW Detroit and Inkster are located in Wayne County, Michigan and Flint is located in Genesee County, Michigan. Recent findings by the County Health Rankings (University of Wisconsin Population Health Institute and Robert Wood Foundation) indicate disturbing trends in health behavior and overall health outcomes in Wayne County and Genesee County. Out of 82 counties in our state, Wayne County ranked second-to-last and Genesee County ranked last in health behavior. Both counties also ranked at the bottom in terms of diet, exercise and physical activity (2010).

EnhanceFitness (EF) is an evidence-based physical activity program specifically designed for older adults (age 60 and older). Certified and EF-trained fitness instructors implement the program, using standardized EF protocols. The program is low-cost and easily adapts to community facilities. It has been successfully implemented in senior centers, health clubs, community centers, and retirement communities.

Participants attend a one-hour physical activity program three times a week. The program focuses on cardiovascular conditioning, resistance and strength training, and flexibility and balance training.

Functional fitness assessments are conducted for: identifying at-risk participants; program planning and evaluation; and goal setting and increasing participant motivation. The fitness assessments include balance and mobility; upper body strength; and lower body strength. EF will complement the existing Greater Flint Health Coalition Commit to Fit campaign and the Crim Foundation Active Living campaign in Flint. Expanding the existing offerings of EF to include evening classes in Inkster will fill a gap that was identified during the community assessment. Establishing EF sites in NW Detroit will bring low-cost physical activity to a community in need of safe opportunities to be more active. This project will use social marketing strategies to increase use of environmental supports for physical activity created through the project.
## Year Two Objectives to Increase Opportunities to Engage in Low-Cost Physical Activity

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measured By</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2012, increase participation in Flint’s Smart Commute initiative from 12 to 20 organizations including churches and neighborhood groups as well as worksites.</td>
<td>Number of organizations registered and tracking activity</td>
<td>Crim Fitness Foundation</td>
</tr>
<tr>
<td>By August 31, 2012, increase opportunities for safe, low cost physical activity by expanding the number of sites offering EnhanceFitness classes in Flint and NW Detroit by at least 2 in each community.</td>
<td>Number of EF sites</td>
<td>Project Enhance</td>
</tr>
<tr>
<td>By August 31, 2012, workgroups in the NW Detroit and Inkster coalitions will develop an action plan that explores improvements to existing parks to enable safe, free physical activity opportunities and investigate increasing green space that is accessible by foot or bike.</td>
<td>Action Plan completed</td>
<td>Walkability surveys, Photovoice, Workgroup reports</td>
</tr>
<tr>
<td>By August 31, 2012, at least 3 community-based organizations/worksites in Inkster and NW Detroit will promote worksite wellness that includes point-of-decision prompts to encourage increased physical activity.</td>
<td>Evidence of point-of-decision prompts</td>
<td>Written policy, Photographic evidence</td>
</tr>
</tbody>
</table>

## Long Term Objectives to Increase Opportunities to Engage in Low-Cost Physical Activity

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measured By</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2013, establish at least 2 Enhance Fitness evening classes in Inkster.</td>
<td>Number classes offered after 5 p.m.</td>
<td>Project Enhance</td>
</tr>
<tr>
<td>By August 31, 2015, work with city officials to ensure that Active Living initiatives are included in the Flint City Master Plan.</td>
<td>Inclusion of Active Living initiatives in Flint Master Plan</td>
<td>City of Flint, Crim Foundation</td>
</tr>
<tr>
<td>By August 31, 2015, increase number of sites offering EF classes in Flint and NW Detroit by at least 3 in each community.</td>
<td>Number of EF sites</td>
<td>Project Enhance</td>
</tr>
<tr>
<td>By August 31, 2015, at least 10 worksites in Inkster and NW Detroit are promoting worksite wellness that includes point-of-decision prompts to encourage increased physical activity (e.g. encouraging use of stairs, walking on lunch breaks, etc.)</td>
<td>Evidence of point-of-decision prompts</td>
<td>Written policy Photographic evidence</td>
</tr>
<tr>
<td>By August 31, 2015, a total of 8 CHWs will be trained to conduct EnhanceFitness.</td>
<td>Number of CHWs trained</td>
<td>MDCH</td>
</tr>
</tbody>
</table>
**Chronic Disease Management.** The process of completing the CHANGE Tool identified a significant need to improve chronic disease management by addressing gaps in service through Diabetes Self-Management, diabetes group visits, support groups, and Diabetes-PATH. In addition, focus groups identified a lack of trust in the health care system as an impediment to seeking diabetes treatment and support. Knowledge and understanding are important ingredients in the self management of diabetes in terms of the disease itself, its origin, effects, medication side effects, progression, optional treatments, available resources, and possible outcomes. The need to give assistance in these informational and educational gaps requires a diverse approach that demands the use of existing portals. Group support, better health plan resource connections to both physicians and patients, resource coordination, and personal & group contact through trusted channels (community health workers, church, block club members, etc.) can provide assistance with filling in gaps. In addition, local policy support as an environmental inducement can provide a basis for building collaborative strength and serve as a catalyst for systemic change.

Over half of the people with diabetes in Michigan (55%) have not participated in a Diabetes Self-Management Education Program (DSME), which is the basic, evidence-based source of essential knowledge and skills needed for effective, sustainable self-care. Despite recommended education guidelines, previous research indicates that 50% to 80% of persons with diabetes have significant deficits in knowledge pertaining to the management of their disease, and fewer than half of those with type 2 diabetes have ideal glycemic control (Saydah, Fradkin, Cowie, 2003). Research also reveals that initial improvements made after DSME diminish after 6 months (Norris, et. al., 2002).

In Michigan, the Stanford Chronic Disease Self-Management (CDSM) Program is known as PATH, an evidence-based program for people with chronic disease that emphasizes the patient’s role in managing their illness and building self-management skills so they can be successful in adopting healthy behaviors. It has demonstrated significant participant improvements in exercise, nutrition, cognitive symptom management, communication with health care providers, general health status, energy levels and social/role activities limitations. Diabetes PATH is similar in structure and process but focuses on behaviors for better control and care practices in adults living with type 2 diabetes. The content for Diabetes PATH is based on research by the Stanford Patient Education Research Center and meets the content standards of both the ADA and the AADE. The program, consisting of community-based
workshops conducted once a week for 2.5 hours over a six-week period, is facilitated by trained co-leaders. A network of referral partners throughout the community will be used to promote workshops and recruit participants. The program emphasis is on creating personal action plans and setting practical, achievable goals. The evidence for the outcomes of the Diabetes PATH program show that participants, as compared with people who did not take the workshop, demonstrated improved health status, health behavior, and self-efficacy, as well as fewer emergency room visits. In contrast to results found with traditional DSME, at one year, the improvements made with Diabetes PATH were maintained.

To address the need for trusted support in reaching out for diabetes care, the strategic plan includes Community Health Worker (CHW) involvement. A CHW is a front-line worker in public health who is a trusted member of the community being served, commonly engaged in direct outreach to vulnerable populations. The CHW is uniquely knowledgeable of individual, family, and community needs, including cultural characteristics, behaviors, and attitudes. They can serve as a unique intermediary by explaining the complexities of the system to help individuals and families understand and access services more readily, and communicating about individual and community cultures and needs to help the service delivery system improve access to higher-quality services. The CHW builds individual and community capacity by increasing individual, family, and community self-sufficiency and health knowledge, improving collaboration between service delivery agencies and the community, and influencing attitudes and practices through a range of activities such as community education, informal counseling, social support, and advocacy. The CHW is not necessarily employed by a health care clinic but can provide leadership for evidence-based programs and connect clinics to these programs.

As widely respected community residents, community health workers can help facilitate access to these resources, but such advisers remain underutilized in most areas. CHWs can promote better health by creating and encouraging use of community-based activities and programs, helping individuals adopt healthier lifestyles, and serving as a link between consumers and health professionals. In minority communities, these workers can serve as a critical component of an environmental approach to community health, which recognizes that health-related behaviors represent part of a large social system of behaviors that can be influenced by the community.
**Year Two Objectives to Promote Chronic Disease Management**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measured By</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2012, provide at least 2 <em>Diabetes PATH</em> workshops in each community of Inkster, Flint, and NW Detroit.</td>
<td>Number of workshops held</td>
<td>MDCH</td>
</tr>
<tr>
<td>By August 31, 2012, increase the number of sources referring to diabetes self-management programs by at least 5 in each community.</td>
<td>Health plan data and self report by referral sources</td>
<td>Health Plan data Self report by referral sources</td>
</tr>
<tr>
<td>By August 31, 2012, train at least one CHW to conduct <em>Diabetes PATH</em> in each community.</td>
<td>CHW trained Number of workshops conducted by CHW</td>
<td>MDCH</td>
</tr>
<tr>
<td>By August 31, 2012, establish a diabetes support group within the city of Inkster.</td>
<td>Support group established</td>
<td>WWFHC IPHC partners</td>
</tr>
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**Long Term Objectives to Promote Chronic Disease Management**

<table>
<thead>
<tr>
<th>Objectives</th>
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</tr>
</thead>
<tbody>
<tr>
<td>By August 31, 2014, a <em>Diabetes Navigator Program</em> will be established in Inkster.</td>
<td>Program established</td>
<td>WWFHC</td>
</tr>
<tr>
<td>By August 31, 2015 a county Health Day will occur. The initiative intends to bring Flint organizations together to share resources with community members.</td>
<td>Event held. Number of attendees.</td>
<td>Health Department and local media</td>
</tr>
<tr>
<td>By August 31, 2015, the City of Flint will pass an obesity resolution.</td>
<td>Successful passage of the resolution.</td>
<td>Local media and legislative record</td>
</tr>
<tr>
<td>By August 31, 2015, increase the overall proportion of <em>Diabetes PATH</em> participants who report monitoring blood glucose daily and increasing physical activity levels by at least 5%.</td>
<td>% increase in blood glucose monitoring and physical activity levels</td>
<td>Pre/Post Survey, MDCH evaluation form</td>
</tr>
<tr>
<td>By August 31, 2015, a total of 8 CHWs will be trained to conduct <em>Diabetes PATH</em>.</td>
<td>Number of CHWs trained</td>
<td>MDCH</td>
</tr>
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</table>

**Diabetes Support and Management Information Sharing.** It is our goal to weave relevant materials from the National Diabetes Education Program (NDEP) throughout the project. To that end, we have begun to educate community stakeholders about NDEP and its available resources. During the April 2011 Advisory Council (AC) meeting, NKFM consultant Sandra Parker presented an overview of NDEP, who can benefit from NDEP materials, and how to access all things NDEP. She also shared
with the team about NDEP’s Facebook page and YouTube channel. A portion of the *Debilitator* video was played and Ms. Parker showed the *New Beginnings* materials and explained how they could be used in conjunction with the video. The presentation was well-received by the Advisory Council and was replicated during a FBHT LSC meeting and plans are underway to provide the presentation to the IPHC and DCAD, as well.

Additionally, NDEP materials have been distributed in each of the three communities, as well as to a wider audience via the internet and through our partner organizations and programs. The largest use of NDEP materials has been in a grassroots advertising campaign using storefront posters. Two posters (30” x 46”) were adapted from the NDEP “Take small steps to see big rewards” and “Managing Diabetes: it’s not easy, but it’s worth it” campaigns. Twenty-one posters are currently in place in the three communities.

Members of the community coalitions have also been asked to distribute smaller sized posters with the same message to local community businesses and organizations. Another means of distributing NDEP materials has been through social networking. At least once a week an NDEP message has been posted on NKFM’s Facebook page or on the Facebook pages of the individual coalitions. In addition, Twitter has been used to share NDEP messages to our followers.

The project aims to support and enhance mechanisms that will combine community messages concerning available resources for diabetes care. The plan proposes use of existing mediums enhanced with NDEP materials, and advocating for improved health literacy through collaborations with existing entities. These mediums and entities will include *Facebook*, *YouTube*, and local media. Communication and education permeate all areas requiring change. Information and resources exist but are not well publicized. Technological tools and media outlets are definitive but by no means conclusive and comprehensive. Personal contact, indirectly or by word of mouth are necessary in that many communities are informed through influential members and resource connections. Collaborating with existing resource organizations
with materials such as those developed by NDEP can be effective when combined with diverse communicative methodologies. Health literacy efforts must be accomplished with collaborative entities with far reaching responsibilities such as health departments and cities.

<table>
<thead>
<tr>
<th>Year Two Objectives to Disseminate Diabetes-Related Support and Management Information Objectives</th>
<th>Measured By</th>
<th>Data Sources</th>
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</thead>
<tbody>
<tr>
<td>On a monthly basis through August 31, 2012, diabetes information will be distributed through social media, community events, and local media and by engaging faith based organizations, neighborhood groups and community centers as distribution points.</td>
<td>Volume of information disseminated, Number of “friends” and “likes” on Facebook</td>
<td>Existing Resources</td>
</tr>
<tr>
<td>By August 31, 2012, coordinate the ongoing dissemination of NDEP materials and messages to at least 15 partner organizations throughout Flint, NW Detroit, and Inkster.</td>
<td>Number of partner organizations distributing NDEP materials</td>
<td>Self report from partner organizations</td>
</tr>
<tr>
<td>By August 31, 2012, implement at least 3 diabetes control awareness campaigns using NDEP resources.</td>
<td>Number of campaigns completed</td>
<td>Existing Resources</td>
</tr>
<tr>
<td>By August 31, 2012, work with community members to gather at least one personal story from each community to use in outreach and media efforts.</td>
<td>Number of stories garnered</td>
<td>Existing Resources</td>
</tr>
<tr>
<td>By August 2012, develop and pilot a health literacy training as an EF add-on to educate at least 50 EF participants total in Inkster and Flint.</td>
<td>Development of a health literacy training program, Number of EF sites providing health literacy training, Number of EF participants trained in health literacy program</td>
<td>Progress Report, EF attendance forms, Health literacy curricula</td>
</tr>
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<th>Long Term Objectives to Disseminate Diabetes-Related Support and Management Information Objectives</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Between August 31, 2012 and August 31, 2015, gather at least one personal story per year each from Flint, NW Detroit, and Inkster to use in outreach efforts.</td>
<td>Number of stories garnered</td>
<td>Media stories</td>
</tr>
<tr>
<td>By August 31, 2013, develop a CHW program to use the NDEP New Beginnings guidebook and corresponding Debilitator video in at least 3 sessions/year.</td>
<td>Program established, Number sessions held, Number of attendees</td>
<td>Attendance sheets, CHW program agreements</td>
</tr>
</tbody>
</table>
By August 31, 2015, coordinate the ongoing dissemination of NDEP materials and messages to at least 40 partner organizations throughout Flint, NW Detroit, and Inkster.

| Number of partner organizations distributing NDEP materials | Self report from partner organizations |

**Policy Change.** For the past several years, state funding for prevention programs has been targeted by budget cuts. In October 2009, the Diabetes Outreach Networks were closed by these cuts. The *Community Conversations Feedback Report*, generated by the Health Disparities Reduction and Minority Health Section of MDCH, found that participants voiced the concern that change related to policy, laws, funding distribution, and education was needed at the local, state, and federal levels. Eliminating inequities in the social determinants of health will likely require long-term commitment and the use of several approaches. It must be recognized that there are many factors that contribute to the complexities around health disparities and that these complex factors will require time and substantial effort to affect positive change. It is by sharing challenges and successes in the efforts to change social determinants that communities can learn from each other how to work to achieve health equity.

Achieving health equity requires creating equal opportunities for health and gives attention to people with the greatest health needs and least resources. It is important, however, to consider the social determinants of health (SDOH). The CDC reports that social determinants of health are the root of health risk behaviors in low-income and racial/ethnic minority populations. SDOH include: poverty; racism and discrimination; chronic stress; residential, economic or racial segregation; and lack of occupational and educational opportunities. In addition to influencing health behaviors, SDOH lead to disparities in access to care and poor quality of care. As we move to address health disparities, this project will seek opportunities to address both health inequities and the social determinants of health in program interventions. Each intervention brings new information and opportunities about strategies that can be used to improve SDOH. The Advisory Council and LSCs will work with project leadership and partners to develop recommendations for policy and environmental change that will influence the reduction of diabetes-related health disparities. Awareness of health disparities related to diabetes is inadequate and
recommendations for the development of future policies that affect social determinants of health at the organizational, local, and state levels are needed. Local governments generally create binding laws within their borders by passing ordinances. A resolution, on the other hand, shows the government's interest or commitment to pursuing a certain issue - such as diabetes prevention. Because resolutions are more informal than ordinances, they are often procedurally easier to enact and can be a great way to encourage an otherwise reluctant local legislature to take its first steps towards longer-term and more comprehensive action.

Policy makers making informed decisions on issues that impact people with diabetes will be achieved by working collaboratively with community partners, focusing efforts on priority policy issues, environmental change, and generating new information about strategies that can be used to improve social determinants of health that influence diabetes. This project will identify, develop, and disseminate model legislation and policies addressing health disparities.

<table>
<thead>
<tr>
<th>Year Two Objectives to Stimulate Policy Change</th>
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</thead>
<tbody>
<tr>
<td>By August 31, 2012, each coalition will develop 1 policy recommendation related to nutrition, 1 policy recommendation related to chronic disease management, and 1 policy recommendation related to physical activity.</td>
<td>Policy recommendations documented</td>
<td>Quarterly report, Workgroup reports from community coalitions</td>
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<tr>
<td>By August 31, 2015, Policy Workgroups will work together to see that at least four total policies related nutrition, chronic disease management, and/or physical activity are adopted at the organizational, municipal, or state level.</td>
<td>Evidence of adopted policies</td>
<td>Written documentation of policies</td>
</tr>
</tbody>
</table>

**Evaluation Overview**

Evaluation mechanisms will focus the design to assess the issues of greatest concern to stakeholders with attention to purpose, feasibility, users, uses, questions, best practices and methods, and agreements about roles and responsibilities; gathering credible evidence that reflects change. The purpose of the evaluation will be to assess the effects of building community structure and support for healthy lifestyle programs.
and to assess the long-term sustainability of applied activities. Evaluation efforts will address both project process and outcomes. Methodology for evaluation will use mixed methods approaches.

1) A majority of the evaluation will be observational, using surveys at multiple time periods. A minimum time series of baseline at the first year and follow-up in the final year will be used.

2) A quasi-experimental component is also planned using health plan data to compare the health status of people in the communities using the programs put in place versus those who do not use the programs. This analysis will occur at one point in time and in the fourth year of the grant.

3) GIS will be used for spatial analysis of community characteristics and location of healthy lifestyle resources. Analysis will be at the neighborhood scale using parcel data from the City Assessors office, geo-coded locations of assets and activities, and health data from the local public health departments. The City of Detroit is part of the National Neighborhood Indicators Partnership and will likely have a more diverse set of community data available to work with. This analysis will be conducted early in the grant process to identify gaps that may need to be addressed.

4) Key informant interviews will be used to collect participant stories and qualitative data. Additionally, process evaluation will be continuous assuring that activities and products are completed in a timely manner.

NKFM will work in concert with various coalition partners involved in the above activities to perform the evaluation. NKFM will oversee the collection and tracking of outcome data related to the program objectives. The UMCMCD will assist with the evaluation design, as needed, provide technical assistance for local data collection, and oversee data management and analysis of data provided by the participating groups. Other partners at all levels will be asked to engage in evaluation processes as indicated by the strategic plan objectives.

The evaluation plan will also include a risk management section. In this section, we will identify foreseeable risks that would hinder the completion of the work plan (e.g., loss of key staff) and plan for possible contingencies. While all potential risk is not foreseeable, this form of planning would help to more quickly resolve the most probable events.

**Gather Credible Evidence.** Evaluation mechanisms will ensure the project’s use of appropriate and available indicators and documentation that reflect credible sources and attention to quantity, quality and the logistics of procedure and methods. Some data collection tools will be modified from existing
tools, while others will need to be created specifically for the task. The DPCP already has data collection tools in place for the Diabetes PATH and EnhanceFitness programs. A survey to capture stakeholder engagement and satisfaction will be modified from surveys used for the statewide diabetes coalition. Surveys to measure consumption of healthy food, physical activity, usage of community resources that exist prior to the strategic plan activities, and usage of community resources that will be put in place due to the strategic plan activities will be developed using a combination of existing questions from the Healthy Hair Starts with a Healthy Body program and the Michigan Diabetes Prevention Course. Cultural sensitivity will be a priority in developing or modifying all data collection tools, and NKFM already has cultural awareness in these communities from prior experience. Data collection for both process and outcomes will be used to evaluate the progress of the strategic plan and outcome indicators. Short-term indicators are connected to and build toward long-term indicators.

**JUSTIFY CONCLUSIONS.** Evaluation mechanisms will ensure the project’s justification of conclusions by linking the evidence gathered to the agreed-upon standards set by the stakeholders, and with participation of stakeholders in all aspects of setting standards, analysis, interpretation, judgments and recommendations. As information comes in related to the work of this project, it will be entered into a database program and organized in ways that will allow results to be shared with stakeholders. By encouraging participation and input from all project partners, it is the intent of this project to create a participatory process for the sharing of results and interpretation of findings. If patterns deviate from what is expected, then there will be discussions to determine whether more training is needed or, if a change in procedure is warranted. Ongoing reports will be shared with partners at all levels on a quarterly basis. LSC members will have the opportunity to discuss initial interpretation of the results and add their local perspective to help explain the results. When a final interpretation of the results is agreed upon, the Leadership Team and Advisory Council will then guide stakeholders in making recommendations based on both the quantitative results and their qualitative experience in implementing the activities.

The first set of recommendations will focus on the sustainability of community activities after the grant period ends. The activities that the stakeholders value most will shape prioritization of continuing activities and allocation of available resources. These recommendations will be used to build a sustainability plan, including assigning responsibility for continuing activities and timelines. The second set of recommendations will be the basis for training other public health practitioners in how to apply the activities and lessons learned in their own communities. Stakeholders will help to identify contextual factors related to findings and how the findings might adapt to social and environmental situations in other geographic areas.
The evaluation for this project will be community-based, with participation and leadership from stakeholders in the focus populations – those most affected by the work of this project in Flint, NW Detroit, and Inkster. Although partnerships already exist for this work, additional engagement of key stakeholders across the multiple sectors related to elimination of diabetes-related health disparities in vulnerable populations will continue throughout the grant period and beyond.

**Dissemination Plan**

Building on NKFM’s existing publication accomplishments and to positively impact the health of vulnerable populations, dissemination of research will occur via at least one publication in a peer-reviewed journal and two or more state- or national-level presentations regarding project accomplishments impacting diabetes-related health disparities. Conferences and research articles will educate the community and professionals wishing to understand best practice recommendations for implementing programs that increase overall health of a community. These conferences will increase accessibility of research results to community members and organizers at a greater rate than publication alone. Presentations will also provide a foundation for eventual publication in peer-reviewed journals. Research presented about the coalitions and programs in Flint, NW Detroit, and Inkster, Michigan will benefit other community-based researchers by adding to the pool of community health literature. In presenting this area of research to policy-makers and physicians, the audience of social science research will expand. The dissemination of information is crucial for the betterment of vulnerable populations and the communities in which they reside, as a way to improve the inadequate social determinants of health.

**References**

2. [http://www.bls.gov/eag/eag.mi_flint_msa.htm#eag_mi_flint_msa.f.6](http://www.bls.gov/eag/eag.mi_flint_msa.htm#eag_mi_flint_msa.f.6)


9. Figures for NW Detroit were averaged across the six selected zip codes for this area. Available at: http://www.city-data.com/city/Inkster-Michigan.html


