Lawndale Health Promotion Project

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Acknowledgements

Evaluation Team

- Lawndale Community Council
- Dr. Cynthia Boyd, Co-PI Team leader
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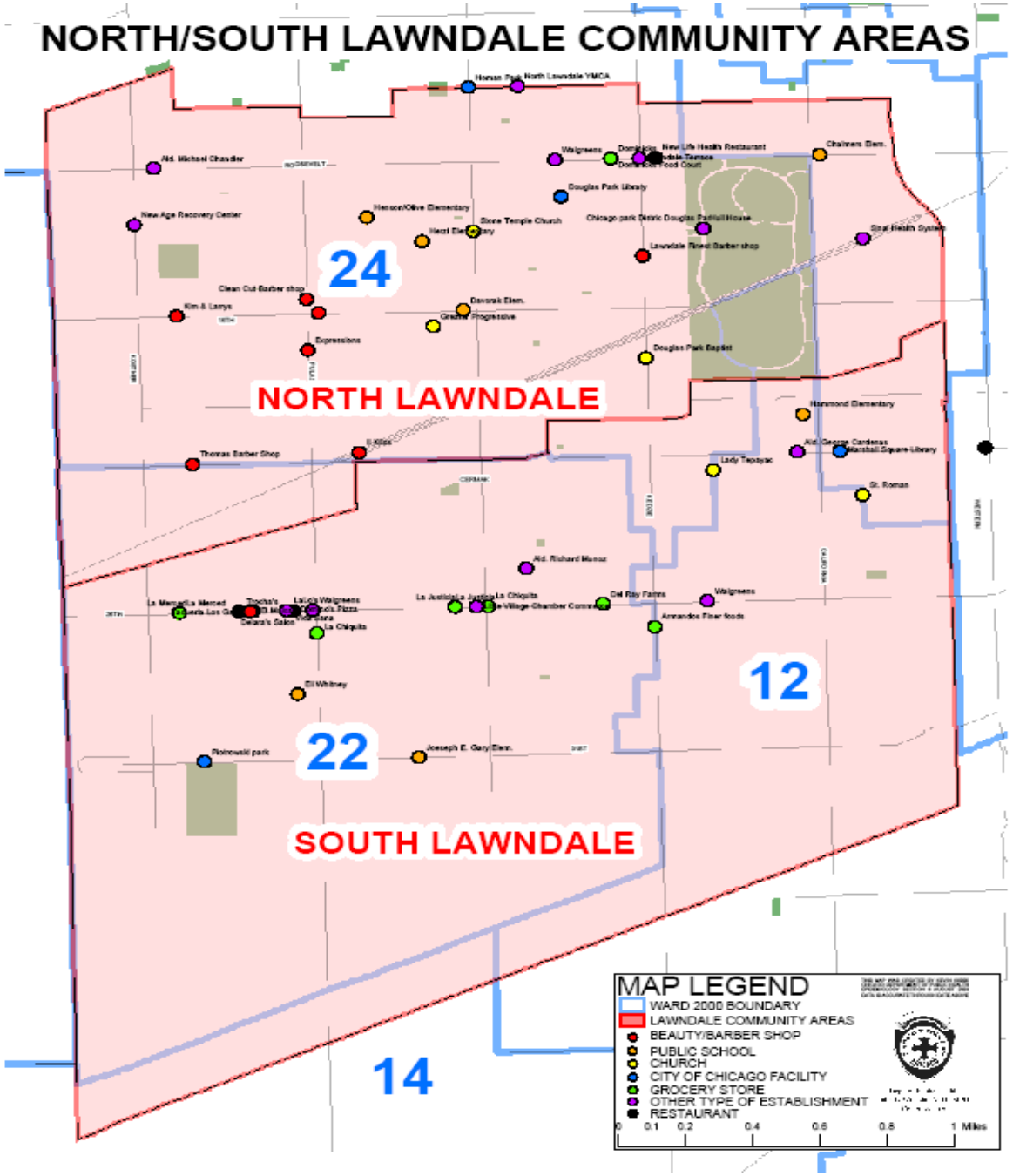
Lawndale Health Promotion Project

A community planned and community based initiative to address health disparities in cardiovascular disease and diabetes in Chicago's North and South Lawndale Communities



Demographic Characteristics of North and South Lawndale in Chicago.

	North Lawndale	South Lawndale
Total population	41,768	91,071
% African American	95%	5%
% Latio	14%	83%
% Unemployed	26%	12%
% below poverty level	45%	27%
Median household income	$18,342	$32,320

Conclusions and Evidence Based Common Sense

- Case management provided by community workers, **works.**
- The success or failure of the community worker was directly related to the how the role was introduced into the organization
- African American and Latino participants both benefited but from *different* engagement approaches
- Older participants were more likely to remain involved for up to 12 months and sustain behavior change

History of The Chicago Lawndale Health Promotion Evaluation

- CDPH community meeting
- Review of epidemiologic data suggested two communities at high risk of diabetes and CVD
- Call to action to respond to RFP
- Community action plan set framework for the Intervention
- Responsive evaluation proposed
- Key stakeholders validated questions

CBPR Principle: Community engagement early in the process

The Evaluation Documents the Evolution of the Chicago Lawndale Health Promotion Project

- Formed the LHPP council

- Enriched needs assessment with community history
- Conducted open meetings to deepen the understanding of the problems and contributors
- Used consensus building approaches to prioritize problems

- End result: comprehensive community action plan

CBPR Principle: Community has continuous involvement in all phases

The Community Action Plan

- **Area I** Identify persons at risk for type 2 diabetes and/or hypertension.

- **Intervention**
  - Intervention- Lay outreach workers conduct **risk assessments**
  - Provide culturally relevant risk reduction mini-education
  - Facilitate referrals and follow-up

The Community Action Plan

- **Area II** Promote of risk reduction and disease control behaviors to self-manage diabetes and reach normal blood pressure, cholesterol, and weight

- **Intervention**: Community worker Case Management
  - Five hundred high-risk residents received intensive case management services
  - Establish partnerships with community providers

The Community Action Plan

- **Area III** Promote quality care among providers
- Intervention
  - Provider educational activities
  - Providers adopted ADA and AHA recommended practices
  - Patients received "Know Your Rights" and disease self-management education

The Community Action Plan

- **Area IV** Enhance the capacity of the community to promote and support healthy living
- **Intervention**
  - Increase access to healthier foods in groceries stores, restaurants and community gardens
  - Increase capacity of local physical activities providers
  - Promote policy changes such as supporting enforcement of City smoking ordinance and loitering laws
  - Expand availability of community-based smoking cessation programs
  - Support community beautification projects

The Community Action Plan

- **Area V** Create and disseminate quality, bilingual, culturally appropriate health messages and media campaign addressing type 2 diabetes, stage 1 hypertension and overall health and wellness.

- Intervention
  - Create and disseminate quality, bilingual, culturally appropriate health message
  - Conduct outdoor media campaign

The Community Action Plan

- **Area VI** **Co**alition capacity, sustainability and institutionalization of programs through collaboration, technical support and research for additional funding
- **Actions**
  - Increase the number of Latino representatives
  - Engage religious, political and business communities
  - Research additional funding sources
  - Provide technical assistance to CBOs to improve grant writing skills and thus increase the funding opportunities.

Evaluation Framework

- Community engaged, defined and owned (formally)
- Responsive to place specific conditions

- Goals:
  - Mobilize community and external assets for change
  - Observe and document differences between the two communities
  - Document the story in varied forms depending on the intended audience

Methods
Community Environmental Assessment

- Environmental analysis
  - Asset mapping
  - Barrier identification
  - Monitoring local events
- Tools:
  - Community Landscape Area Mapping (CLAM)

CBPR Principle: Community contributes to defining the problem, its relevance and importance

Community Landscape Asset Mapping: Overview

11 Lawndale residents walked around and observed specific items

Observed:

- 147 Blocks using Looking Around
- 46 Restaurants using Eating Out
- 33 Grocery Stores using Grocery Shopping

Guided by Dr. Michele Issel UIC School of Public Health

Lessons Learned

Lessons

Health fairs, community announcements and mass distribution of information had minimal impact on the level of community awareness of risk factors for CVD and diabetes over time.

However, individuals receiving the same information in individual encounters demonstrate greater awareness and sustained change in personal behavior.

Lessons

- African Americans were at higher risk of more severe manifestations of chronic illness and based on retention experience, they may require more personalized intervention over a longer period of time.

- African Americans were more likely to report feelings of discrimination

Case Manager/Family engagement

- Peer educators differed in their approach to establishing and then sustaining relationships.
- Latino workers: engagement process was facilitated by shared language, cultural identification, dietary practices and distinctive family roles.
- African American workers : engagement was helped by many of the same factors in addition to spirituality and common experiences interacting with the healthcare system.

Case Management Works

- The number of respondents *not* **familiar with various community resources** decreased between interviews.
- The proportion of people who expressed greater confidence in their health behaviors increased between interviews.

Individual versus Group Intervention

- Case management was effective for both groups
- Latino participants benefited most from group rather than individual encounters.
- African American participants preferred and benefited more from the individual interventions and were more likely to share information in this context.

Case Manger/Provider Relationships

- Case managers were less effective forming influential relationships with the health care providers.
- Relationships were strongly influenced by the manner in which the role and program goals were introduced to the CBO
- Bilingual Case managers appeared to overcome resistance sooner

Individual Change

- Many individuals were very aware of risk factors and verbalized that "they knew better" but found it difficult or did not intend to change.

- Older individuals and those more severely affected by disease were more likely to be aware of risk and involved in interventions to improve their health.

Community Capacity

- Community coalitions change over time and reflect how well internal and external changes are communicated and responded to.
- Members were most involved when coalition activities were focused on dreaming, planning and goals
- When the purpose of meetings assumes a more informational character, attendance, energy and involvement sharply declined.

Thank You

LHPP Community Council

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