Collaborative Work to Reduce Diabetes Disparities in Chicago: The South Side Diabetes Project

Monica E. Peek, MD, MPH
University of Chicago
Midwest Society of General Internal Medicine meeting
September 5, 2014
Project Team

- Marshall Chin
- Monica Peek
- Tonya Roberson
- Anna Goddu
- Molly Ferguson
- Nora Geary
- Deb Maltby
- Yolanda O'Neal
- Kristine Bordenave
- Michael Quinn
- Doriane Miller
- Lisa Vinci
- Andrew Davis
- Elbert Huang
- Nyahne Bergeron
- Jonathan Dick
- Shantanu Nundy
- Seo Young Park
- Neha Setha
- Emily Lu
- Robert Sanchez
- Deborah Burnet
- Karen Kim
- Dawnavan Davis
- Sheila Harmon
- Daniel Rowell
- Yue Gao
- Sang Mee Lee
- Julie Whyte
- Chef Brian Alston
- Shelley Scott
- Mickey Eder
- Peggy Hasenauer
- Louis Philipson
- Marla Soloman
- Hui Tang
- Robert Nocon
- Katie Raffel
- Ndang Azang-Njaah
- Gwen Burrows
- Braunda Anderson
- Melishia Bansa
• Diabetes disparities in Chicago
• Diabetes disparities in Chicago
• South Side Diabetes Project
• Diabetes disparities in Chicago
• South Side Diabetes Project
  – Intervention
• Diabetes disparities in Chicago
• South Side Diabetes Project
  – Intervention
  – Collaboration
    • how established
    • who involved
    • lessons learned
    • collaborative outcomes/products
Diabetes mortality in Chicago
Potential years of life lost in Chicago
• Avoidable diabetes-related hospitalizations
Improving Diabetes Care and Outcomes on Chicago’s South Side

- QI + Disparities
- Geographic areas
- Community + Healthcare systems
- Chronic care model
South Side of Chicago

• Challenges:
  – Poverty
  – Social challenges
  – Food deserts
  – Unsafe recreation
  – Mistrust of healthcare
  – Weakened hospital safety net

• Strengths
  – Historical social, political and cultural traditions
  – Community resources and institutions
  – Healthcare institutions
South Side of Chicago

• **Challenges:**
  – Poverty
  – Social challenges
  – Food deserts
  – Unsafe recreation
  – Mistrust of healthcare
  – Weakened hospital safety net

• **Strengths**
  – Historical social, political and cultural traditions
  – Community resources and institutions
  – Healthcare institutions
Quality Improvement

Community Partnerships

Patient Activation

Provider Training

The Chronic Care Model

Community

Health Systems

Patient

Practice Team

Productive Interactions

2 academic clinics, 4 FQHCs, volunteer faculty/workshop facilitators
Quality Improvement

- Nurse care management
- Diabetes group visits
- Care coordination
- Population Management
- TEAM-BASED CARE
6 partner clinics, project faculty/staff (social psychology, cultural competence, etc).
Provider Training: Patient-Centered Care

• Physicians, nurses, clinic staff

• Workshops
  – Cultural competency
  – Behavioral change
  – Motivational Interviewing
  – Patient/provider communication

• Continuing medical education (CME)
  – resistant HTN, DM management, lipids
6 partner clinics, clinic staff, project staff, others (curriculum dvpmt)
Patient Activation

- Diabetes patient self-management classes
- Communicating with your healthcare provider (SDM)
- Mock grocery store
- Role-play to practice food ordering with local restaurant menus
- **Improved:** SDM self-efficacy & behaviors, DM self-care, diabetes control (HbA1c)
Patient Activation: Mobile Technology

- Interactive text message reminders w/ nurse care managers

- Improvements in:
  - Diabetes self-efficacy
  - Diabetes self-care
  - Quality of life
  - Diabetes control
  - Health care costs

- UCHP (care mgr, costs), CDEs, project team, mHealth
Non-profits, businesses, community organizations, health dept.
# Sustainable Community Partnerships

<table>
<thead>
<tr>
<th>Service</th>
<th>Partner 1</th>
<th>Partner 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food pantries</td>
<td>Chicago Park District</td>
<td>Walgreens</td>
</tr>
<tr>
<td>Pharmacy discounts</td>
<td>ADA &amp; AHA</td>
<td>YMCA</td>
</tr>
<tr>
<td>Farmer’s markets</td>
<td>Grocery store tours</td>
<td>Local chefs</td>
</tr>
<tr>
<td>Fitness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Greater Chicago Food Depository distribution day at KLEO Community Center
Lessons Learned from Collaborative Efforts
Lessons Learned from Collaborative Efforts

• Start small and expand later
Prescriptions for Food and Exercise

- Chicago Park District
- Walgreens
- Farmer’s Market
- Food Depository
Health: part of your treatment plan

Use this sheet to help you follow your doctor's guidance for a healthful eating plan. Read the nutrition labels on all your food products to learn more about what you're putting in your body.

What are Low-Carb Foods?

Carbohydrates (or carbs) include fruits, sweets and starches.

The good news is that you don't have to cut them out. Eating the right portion is important.

AIM for 15 grams or less of carbohydrates per serving, and 45-60 grams or less per meal.

- Tomatoes
- Onions
- Carrots
- Mushrooms
- Tea and Coffee
- Yogurt
- Cottage cheese
- Green, leafy vegetables
- Green, yellow, red peppers
- Eggs
- Tofu
- Fish
- Chicken
- Lean cuts of meat
- Peanut butter

What are Low-Fat Foods?

Go for foods that are reduced or low-fat: these will have at least 25% less fat per serving as compared to the traditional version of the food item.

- Olive Oil
- Avocado
- Fruits
- Vegetables
- Walnuts
- Flaxseeds
- Salmon
- Trout
- Tuna
- Whole wheat bread
- Oatmeal
- Grains

Just what the Doctor Ordered!

What are High-Fiber Foods?

The best sources of fiber have: 5 grams of fiber or more per serving. Food that is a good source of fiber has 2.5 to 4.9 grams of fiber per serving.

- Prunes
- Dates
- Beans
- Oatmeal
- Avocados
- Raspberries
- Figs (dried)
- Apricots (dried)
- Coconut (dried)
- Fortified cereals
- Bran cereals
- Toasted wheat germ

What are Low-Sodium Foods?

Look for foods with less than 140 milligrams of sodium per serving—that's about 1/16 of a teaspoon.

Careful! "No salt added" means no salt added during processing; it does not necessarily mean sodium free!

- Milk
- Eggs
- Sherbert
- Pastas
- Rice
- Fresh fish
- Fresh poultry
- Tabasco
- Vinegar
- Nuts (unsalted)
- Peanut Butter
- Tuna (low sodium)
- Fresh fruit
- Fresh vegetables
- Sour cream

For more information
Food Rx: Incorporation into EMR

- EPIC Rx

Food Rx

Welcome to the Food Rx program! Your doctor has ordered you a Food Rx, or “food prescription”, because eating healthy is an important part of taking care of yourself and your diabetes.

If you have a 61st Street Farmers Market Food Rx, you can take it to the South Side Diabetes project booth at the market (61st and Dorchester) Saturdays from 9:30am-1:30pm and get $9 worth of fresh produce!

The South Side Diabetes Team also has free Farmers' Market tours every Saturday at 10:30am, and we would love to see you there! To register: 773-702-2939.

Your Food Rx will look like EITHER of the two pictures below. BOTH versions work just the same.

Questions? 773-702-2939 www.southsidediabetes.org

For more information: www.southsidediabetes.org 773-702-2939
Food Rx: Market Tours & Health Education
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
Provider Training: Patient-Centered Care

• Champions
  – Clinic/QI members
  – Leadership support

• Workshops
  – Cultural competency
  – Behavioral change
  – Motivational Interviewing
  – Patient/provider communication

• Continuing medical education (CME)
  – Resistant HTN, DM management, lipids
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
KLEO Food Pantry
Patient Activation & Community Partnerships

Patient empowerment classes

Resources
Reinforcement
Sustainability

Pantry partnership
- Free food
- Health information
- Cooking demonstrations
- Exercise lessons

Education
Screening
Resources

K.L.E.O COMMUNITY FAMILY LIFE CENTER
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
• Align with organizational strategic priorities
University of Chicago Medicine

- Urban Health Initiative
- UCM collaborations
  - Faculty at partner FQHCs
  - South Side Health Collaborative
- CommunityRx/HealtheRx

The South Side is talking about

The community expert will know where to send me.

Because these places are all located near me, they’ll be easy to get to.

The HealtheRx will be helpful between doctor visits to know where services are in the community.

What is HealtheRx?

- It is a list of resources targeted toward a patient’s specific health and wellness needs and located near his or her home.
- HealtheRx serves patients in 11 zip codes, through two emergency departments at the University of Chicago Medical Center as well as three local health centers.
- More zip codes and health centers will be added as we expand the program.

How does HealtheRx help people?

- Every HealtheRx is designed to help patients find the resources they need to improve their health, live independently, and manage with dignity.
- Patients and caregivers who use services on the HealtheRx site stimulate local business and help strengthen their communities.

HealtheRx is a true community partnership and a solution that benefits everyone. Together, we can significantly improve health, health care, and strengthen our communities at the same time.

- Darlene Minor, MD
  - Associate Professor of Medicine
  - Program Director for Community Health and Vitality

As a doctor who treats patients on the South Side every day, I need HealtheRx. This new kind of ‘prescription’ goes beyond a diagnosis and medicine. It provides personalized information and support from community resource specialists to help patients stay healthy between clinic visits.

- Tai Long, MD
  - Program Director for Community Health and Vitality

If your prescription: Lose weight! Eat healthier! Stop Smoking! All day long, we tell patients what we think they should do to be healthier, but we fail to make the connections to places and services they can use to stay well, live independently, and manage with dignity. HealtheRx is the connection between health care and self-care.

- Stacy Linsman, MD
  - Associate Professor of Culture and Medicine
  - Project Director, Community

For more information, call (773) 702-1886 or visit www.healtheRx.org

MAPS Corps and HealtheRx are innovative programs from CommunityRx, a flagship program of the South Side Health and Vitality Studies at the University of Chicago Medicine’s Urban Health Institute. They were developed by students in CHI 31500, a course offered by the Department of Health and Human Services. Content is solely the responsibility of the students and has not been approved by the Department of Health and Human Services.
Chicago Public Health Department
Lessons Learned from Collaborative Efforts

- Start small and expand later
- Identify champions
- Find projects of mutual benefit
- Align with organizational strategic priorities
- Work with the media to spread your story
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
• Align with organizational strategic priorities
• Work with the media to spread your story
• Provide coaching and team support
Quality Improvement

- Nurse care management
- Diabetes group visits
- Care coordination
- Population Management
- TEAM-BASED CARE

- QI teams
- QI collaborative
- Clinic Champions
- QI coaching; IHI training
Lessons Learned from Collaborative Efforts

• Start small and expand later
• Identify champions
• Find projects of mutual benefit
• Align with organizational strategic priorities
• Work with the media to spread your story
• Provide coaching and team support
• Utilize principles of CBPR/Community Engaged Research
Working with Community Organizations

- Remember it’s about people
- Start with your friends and/or like-minded organizations
- Build relationships before organizations
- Give before you get
- Nurture equal relationships
- Understand historical, policy, and economic contexts
- Be committed to the cause, not the grant
- Do good work and good people will find you….
Early Lessons From An Initiative On Chicago’s South Side To Reduce Disparities In Diabetes Care And Outcomes

ABSTRACT Interventions to improve health outcomes among patients with diabetes, especially racial or ethnic minorities, must address the multiple factors that make this disease so pernicious. We describe an intervention on the South Side of Chicago—a largely low-income, African American community—that integrates the strengths of health systems, patients, and communities to reduce disparities in diabetes care and outcomes. We report preliminary findings, such as improved diabetes care and diabetes control, and we discuss lessons learned to date. Our initiative neatly aligns with, and can inform the implementation of, the accountable care organization—a delivery system reform in which groups of providers take responsibility for improving the health of a defined population.

Racial and ethnic disparities in diabetes care and outcomes arise from multiple causes. These include differential access to high-quality health care, healthy food, and opportunities for safe recreation; cultural traditions regarding cooking; beliefs about disease and self-management; distrust of medical care providers; and socioeconomic status. Consequently, the solution must be multifactorial. Improving patients’ knowledge and increasing their motivation to make healthy lifestyle changes will have minimal impact if their limited access to healthy food and physical activity is not simultaneously addressed.

To date, few interventions have taken a multifaceted approach to improving outcomes among and practice are encouraging greater interaction and collaboration among health care providers and communities. One driver of this collaboration is the creation of accountable care organizations, as authorized under the Affordable Care Act of 2010. Accountable care organizations are likely to have financial incentives to take responsibility for broad health care outcomes and costs for a defined population. Thus, accountable care organizations are potentially motivated to prioritize evidence-based prevention strategies that build on community resources and create a continuum of care from community settings to health care systems.

Racial or ethnic minorities are disproportionately represented among high-risk patients with complex medical conditions. Thus, accountable...
Collaborative Products

- Papers: academic and community
- Presentations: academic and community
- Webinars
- Video/tools
- Website/online resources
- Media/public health messages
- Sustainable relationships and programming
Thank you!

- Merck Foundation
- NIDDK R18 DK083946
- NIDDK P30 DK092949
- NIDDK K23 DK075006
- NIDDK K24 DK071933
- University of Chicago CTSA Pilot and Collaborative Translational and Clinical Studies Award