



**CCDTR** CHICAGO CENTER FOR  
DIABETES TRANSLATION RESEARCH

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



IMPROVING  
**DIABETES**  
CARE AND OUTCOMES  
ON THE SOUTH SIDE OF  
**CHICAGO**

Monica E. Peek, MD, MPH

University of Chicago

Midwest Society of General Internal Medicine meeting

September 5, 2014

# Project Team

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- Monica Peek
- Tonya Roberson
- Anna Goddu
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- Nora Geary
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- Louis Philipson
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- Robert Nocon
- Katie Raffel
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- Gwen Burrows
- Braunda Anderson
- Melishia Bansa

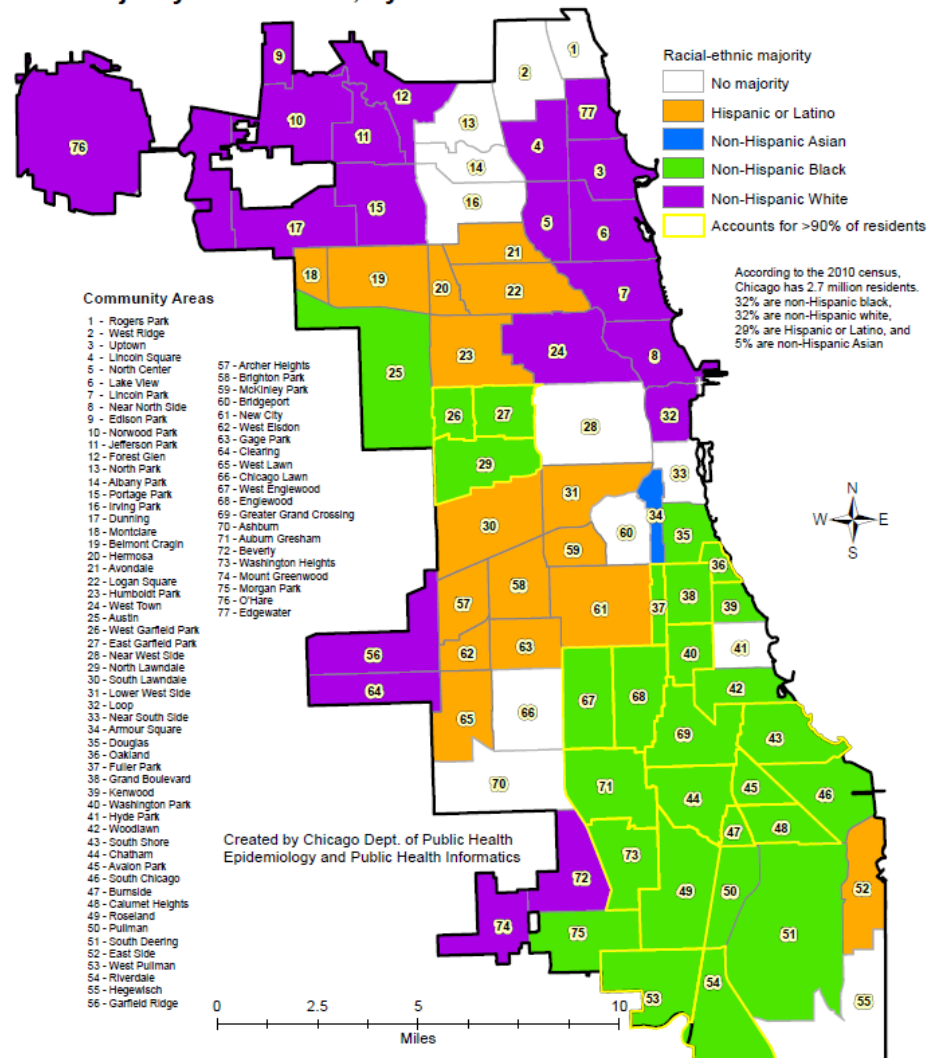
- Diabetes disparities in Chicago

- Diabetes disparities in Chicago
- South Side Diabetes Project

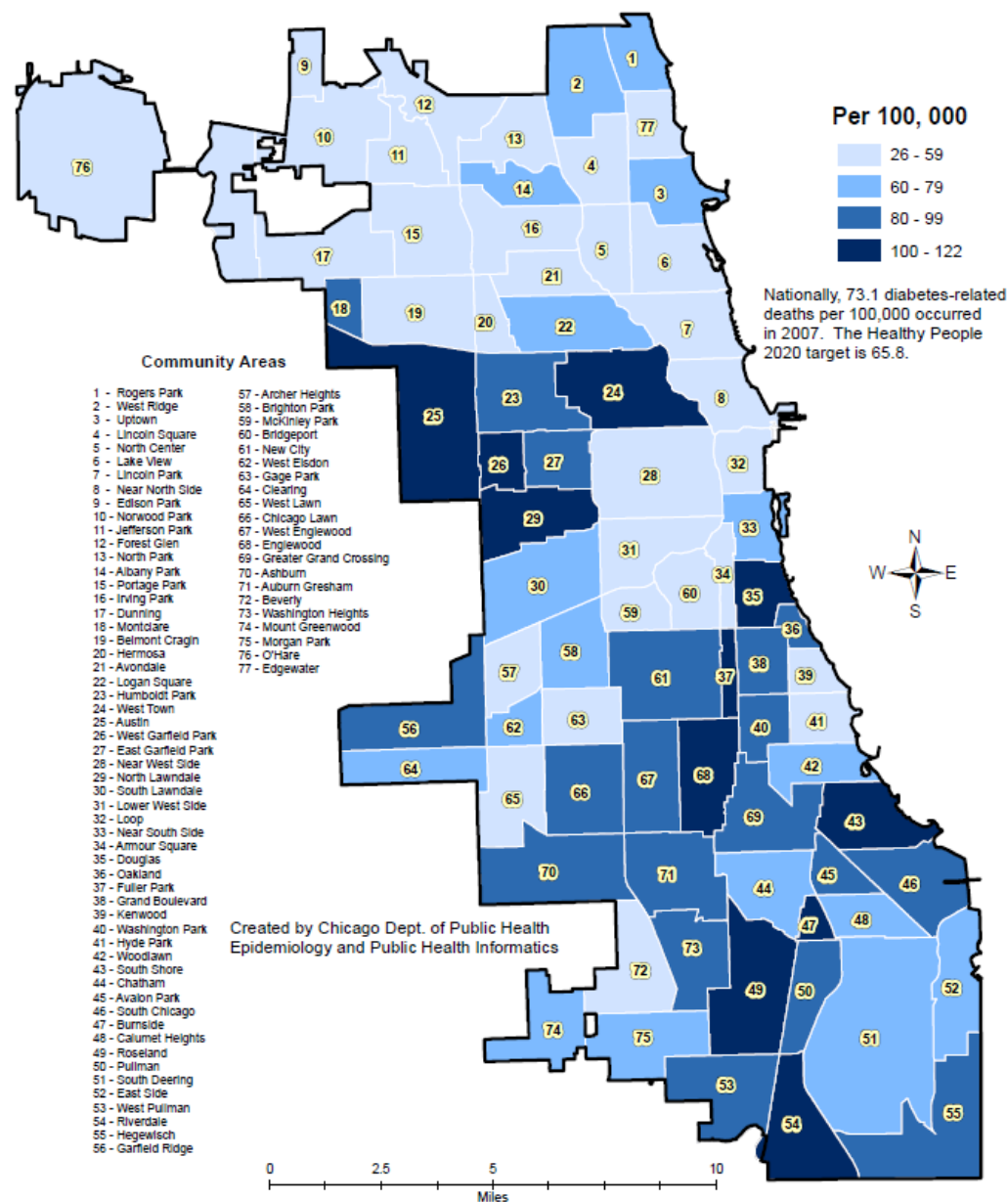
- Diabetes disparities in Chicago
- South Side Diabetes Project
  - Intervention

- Diabetes disparities in Chicago
- South Side Diabetes Project
  - Intervention
  - Collaboration
    - how established
    - who involved
    - lessons learned
    - collaborative outcomes/products

# Chicago community areas by the racial-ethnic group that accounts for a majority of residents, by 2010 U.S. Census counts



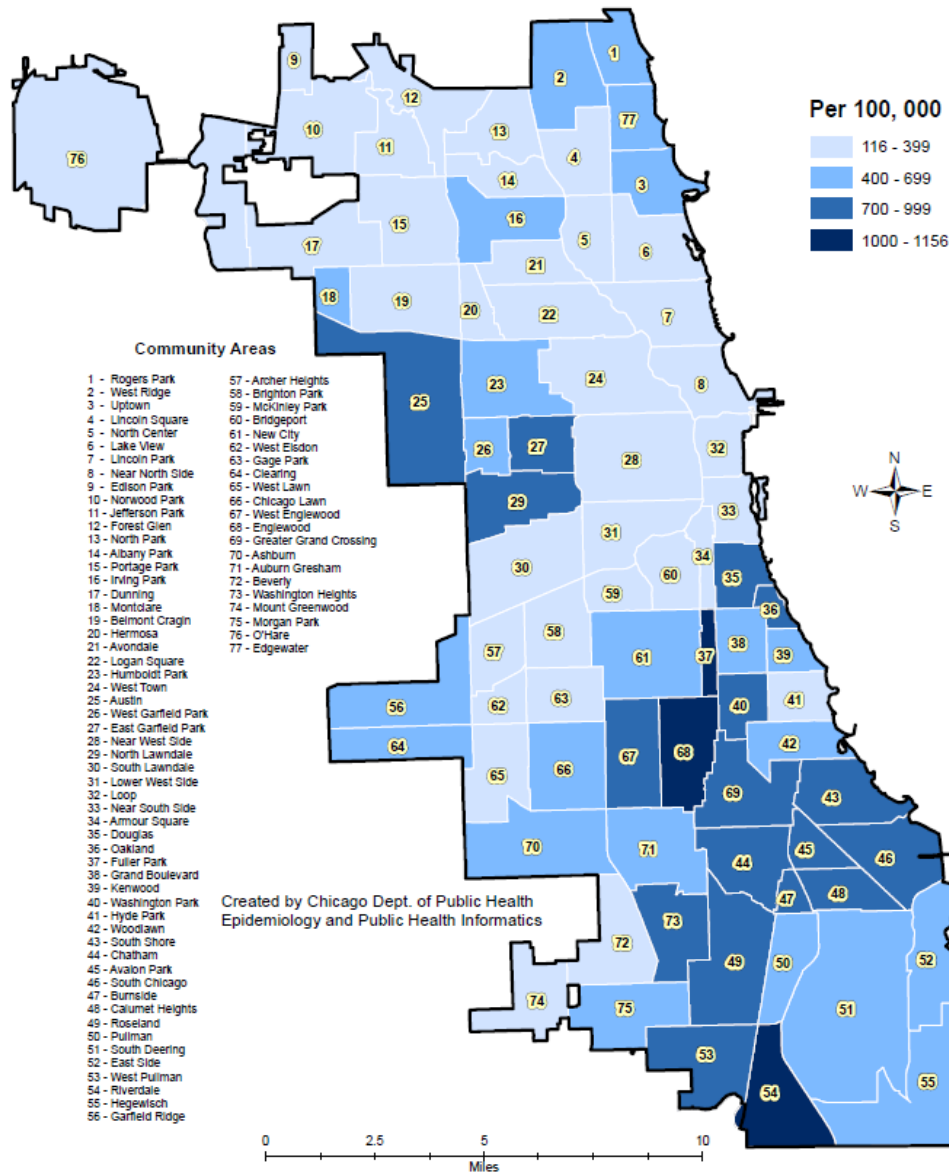
## Average annual adjusted diabetes-related mortality rate by Chicago community area, 2004 - 2008



## Diabetes mortality in Chicago

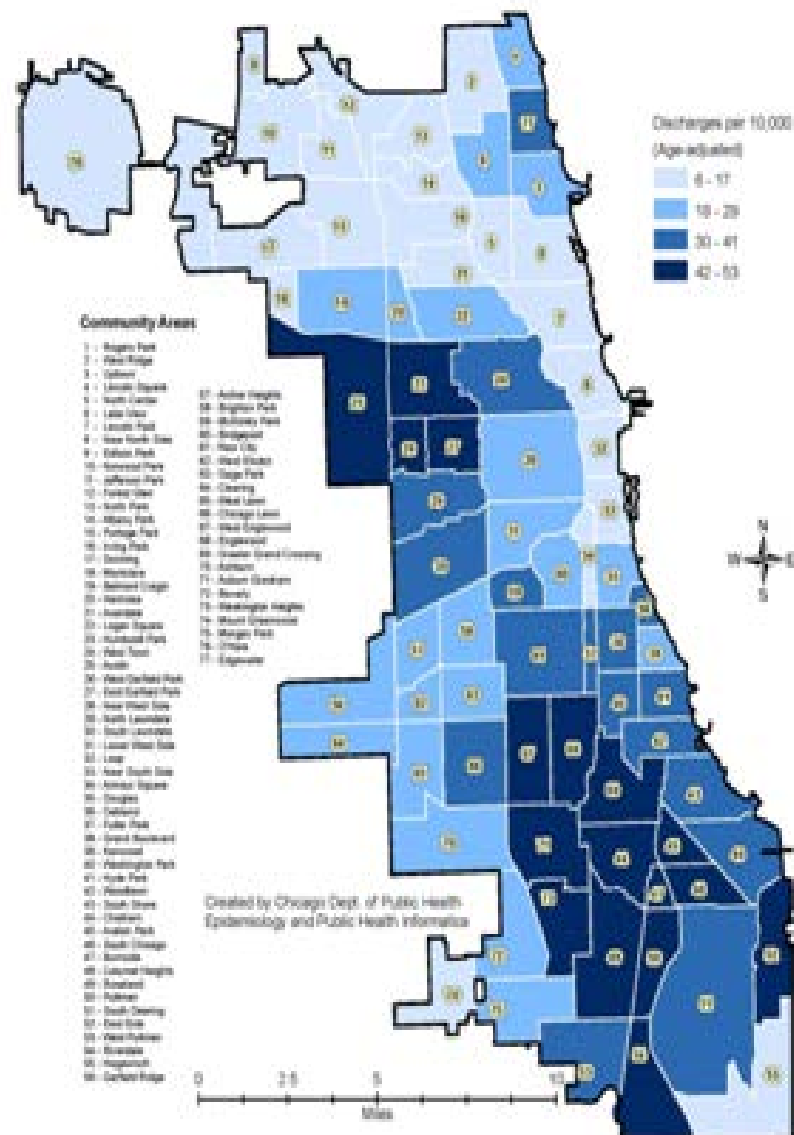


**Average annual years of potential life lost (YPLL) rate  
for diabetes by Chicago community area, 2004 - 2008**



Potential years of  
life lost in Chicago

Imputed diabetes-with-complications hospitalizations per 10,000 residents (age-adjusted) by Chicago community area, 2010



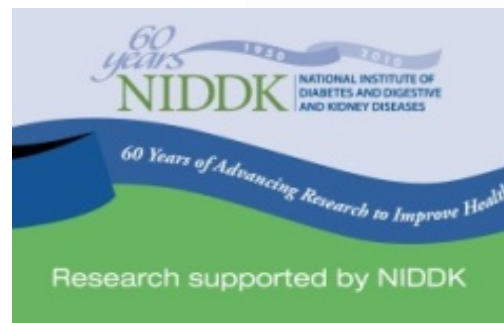
- Avoidable diabetes-related hospitalizations



# Improving Diabetes Care and Outcomes on Chicago's South Side



- QI + Disparities
- Geographic areas
- Community + Healthcare systems
- Chronic care model

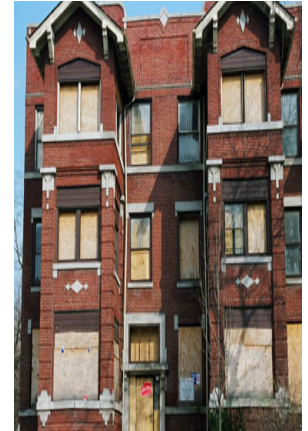




# South Side of Chicago

- Challenges:

- Poverty
- Social challenges
- Food deserts
- Unsafe recreation
- Mistrust of healthcare
- Weakened hospital safety net



- Strengths

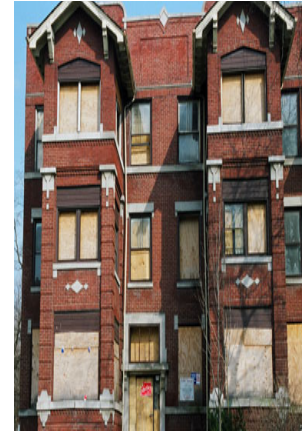
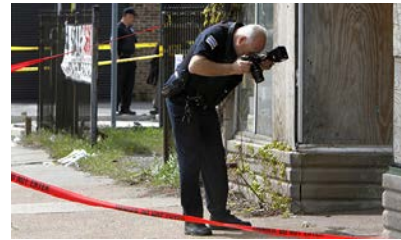
- Historical social, political and cultural traditions
- Community resources and institutions
- Healthcare institutions



# South Side of Chicago

- **Challenges:**

- Poverty
- Social challenges
- Food deserts
- Unsafe recreation
- Mistrust of healthcare
- Weakened hospital safety net

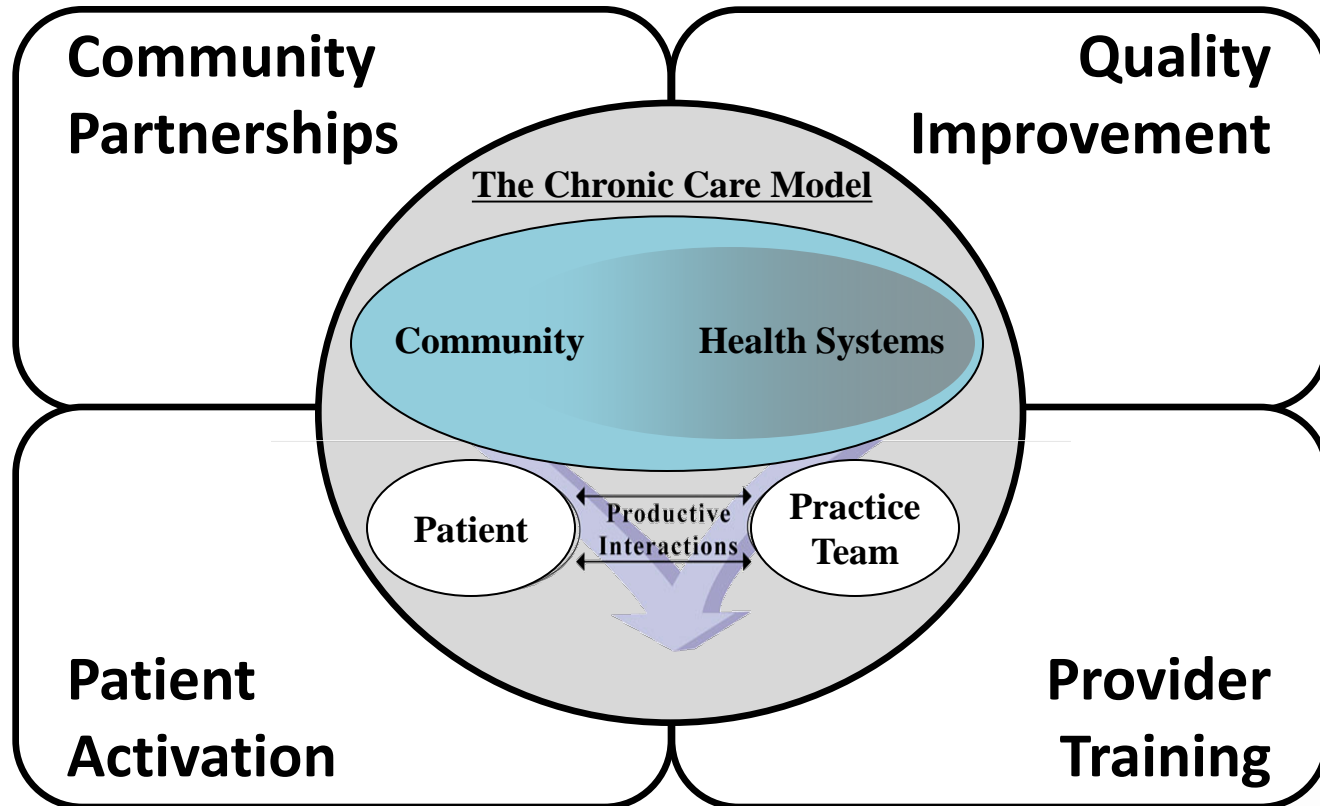


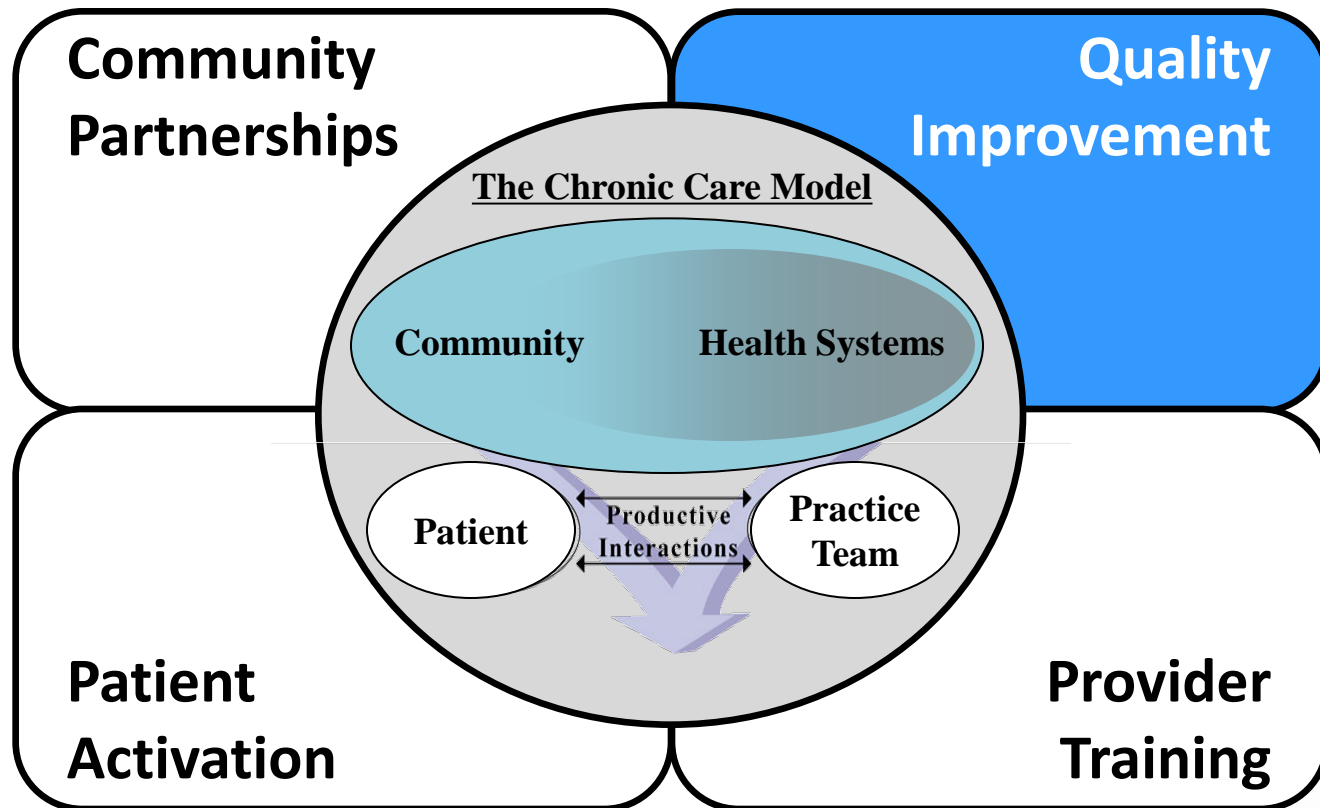
- **Strengths**

- Historical social, political and cultural traditions
- Community resources and institutions
- Healthcare institutions



# Conceptual Model





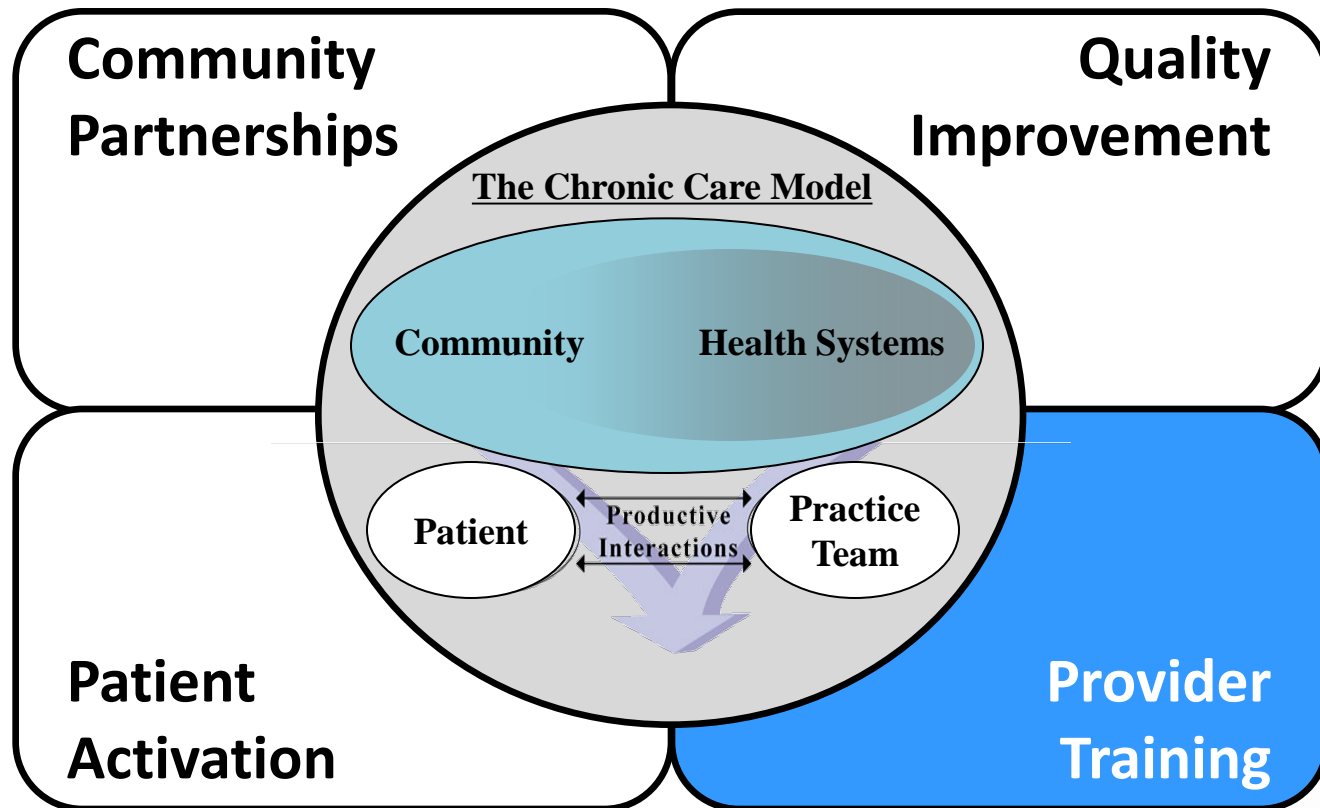
2 academic clinics, 4 FQHCs, volunteer faculty/workshop facilitators



# Quality Improvement

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



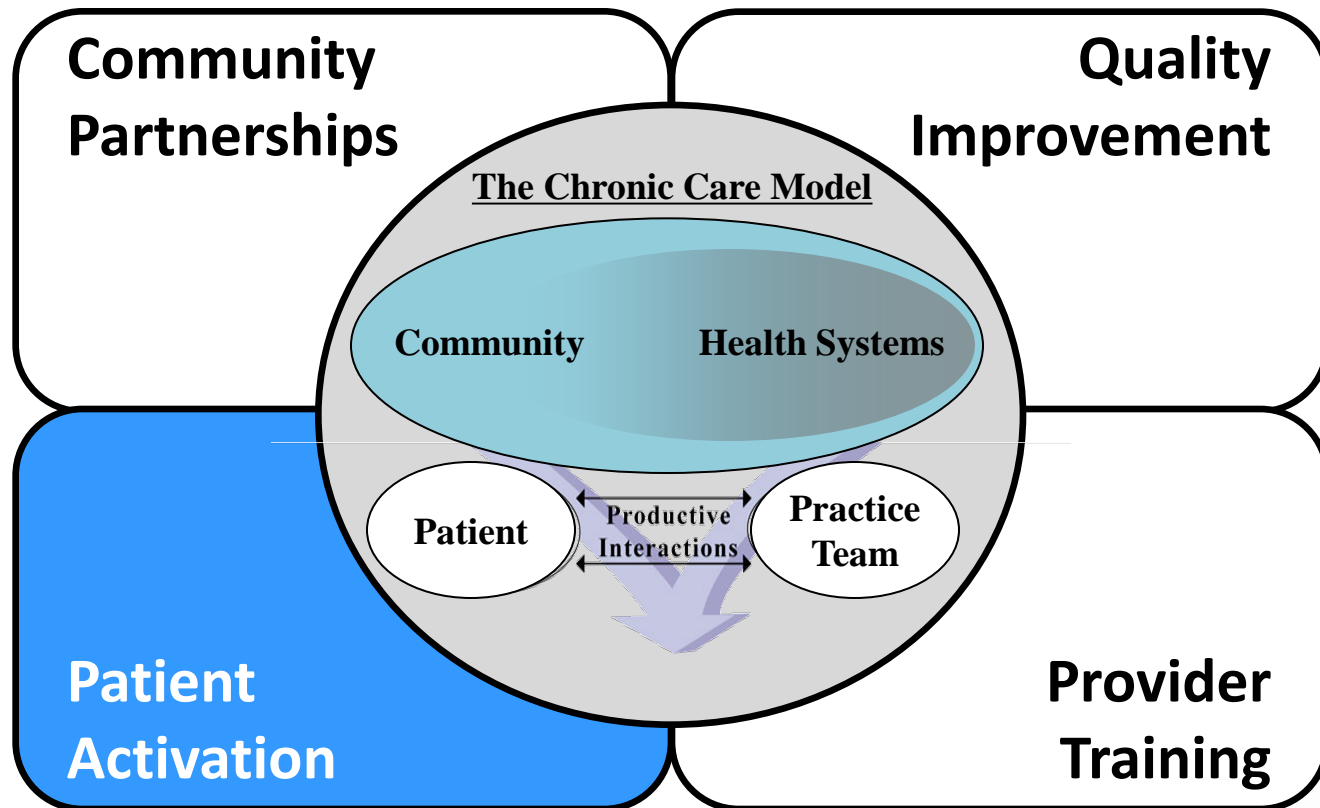


6 partner clinics, project faculty/staff (social psychology, cultural competence, etc).

# 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 development)



IMPROVING  
**DIABETES**  
CARE AND OUTCOMES  
ON THE SOUTH SIDE OF  
**CHICAGO**

# 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)

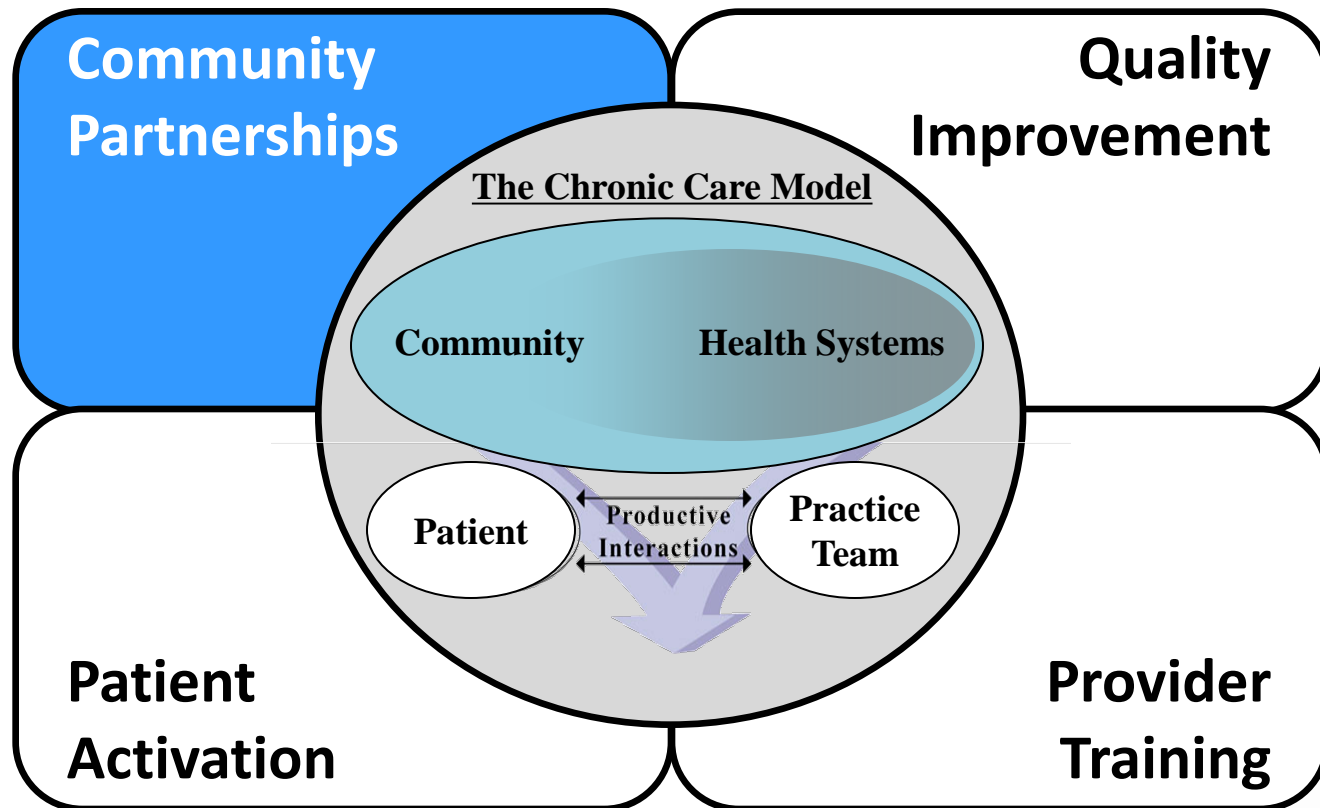


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# Patient Activation: Mobile Technology

- 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

Food pantries

Chicago Park District

Walgreens

Pharmacy discounts

ADA & AHA

YMCA

Farmer's markets

Grocery store tours

Local chefs

Fit



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CHICAGO MEDICINE

**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

61st Street Farmers Market  
**Food Rx**

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IMPROVING DIABETES CARE AND OUTCOMES ON THE SOUTH SIDE OF CHICAGO

www.SouthSideDiabetes.org (773) 702-2939

Provider Name: \_\_\_\_\_ Individual Name: \_\_\_\_\_

Provider License/NPI #: \_\_\_\_\_ Individual DOB: \_\_\_\_\_  
Diabetes: ☐ (to be filled out by individual)

I recommend the following nutrition for this patient:

☐ Low Carb ☐ High Fiber

☐ Low Fat ☐ Low Sodium

See the attached information sheet for food choices that will help you meet these guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 Get \$9 in fresh, healthy produce! See back for more information.

Good as cash! This Food Rx is worth \$10 in fresh produce.

Connect with your food

EVERY SATURDAY  
9 AM to 2 PM  
May 12 - December 15, 2012

 Located on 61st Street between  
Dorchester & Blackstone

GET **\$10**  
worth of  
fresh fruits  
and  
vegetables  
at the  
61st Street  
Farmers  
Market!

 Double your LINK Purchases!  
Up to \$25 per card holder, per market day!

We accept LINK and Senior Coupons  
The 61st Street Farmers Market is a program of the Experimental Station.  
773-241-6044; www.experimentalstation.org

Limit one coupon per customer per offer. Offer expires December 15, 2012. Coupon only good at the 61st Street Farmers Market of Experimental Station. Not valid with any other offer. Customer pays any sales tax. Void if copied or where prohibited.

# 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

*These are Fats - but they have good cholesterol and are heart-healthy!*

*These are Carbs - be sure to watch your*

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	Frozen fruit (no sauce)
Eggs	Frozen vegetables (no sauce)
Sherbert	Whole grain breads
Pastas	Horseradish, mustard
Rice	Cream (half&half, whipping)
Fresh fish	Non-dairy creamer
Fresh poultry	Spices
Tabasco	Herbs
Vinegar	Cream cheese
Nuts (unsalted)	Low-salt Cheeses (monterey, mozzarella, ricotta)
Peanut Butter	Low-salt Crackers (graham, melba toast)
Tuna (low sodium)	Popcorn (unsalted)
Fresh fruit	
Fresh vegetables	
Sour cream	

For more information



IMPROVING



# Farmer's Market Food Rx



# Food Rx: Incorporation into EMR

- EPIC Rx

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**CHICAGO**  
MEDICAL CENTER

Patient Name: Yash Chistest  
5841 S. Maryland Ave  
Chicago IL 60637  
Phone: 312-444-9999  
DOB: 09/11/1984  
Rx: Farmers Market Food Rx

Instructions: I recommend the following nutrition for this patient

☐ Low Carb      ☐ Low Fat  
☐ High Fiber      ☐ Low Sodium

\$9 of free health food at Farmers Market – good as cash!

Ms Urmc, M.D.      NPI #: 3330076123  
5758 S. Maryland Ave.      DEA: 221204867  
340800005600UC  
CHICAGO IL 60637  
Phone: 773-702-6940  
Fax:

Ordered at: 9:52 AM on Sep 4, 2013

## 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 **61<sup>st</sup> Street Farmers Market Food Rx**, you can take it to the South Side Diabetes project booth at the market (61<sup>st</sup> 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.

61st Street  
Farmers Market  
**Food Rx**

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MEDICINE

IMPROVING  
DIABETES  
CHICAGO

[www.SouthSideDiabetes.org](http://www.SouthSideDiabetes.org) (773) 702-2939

Provider Name: \_\_\_\_\_ Individual Name: \_\_\_\_\_  
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See the attached information sheet for food choices that will help you meet these guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Get \$9 in fresh, healthy produce! See back for more information.

Picture of printed Rx here

Questions? 773-702-2939 [www.southsidediabetes.org](http://www.southsidediabetes.org).

For more information: [www.southsidediabetes.org](http://www.southsidediabetes.org) 773-702-2939



# Food Rx: Market Tours & Health Education



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CARE AND OUTCOMES  
ON THE SOUTH SIDE OF  
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# 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



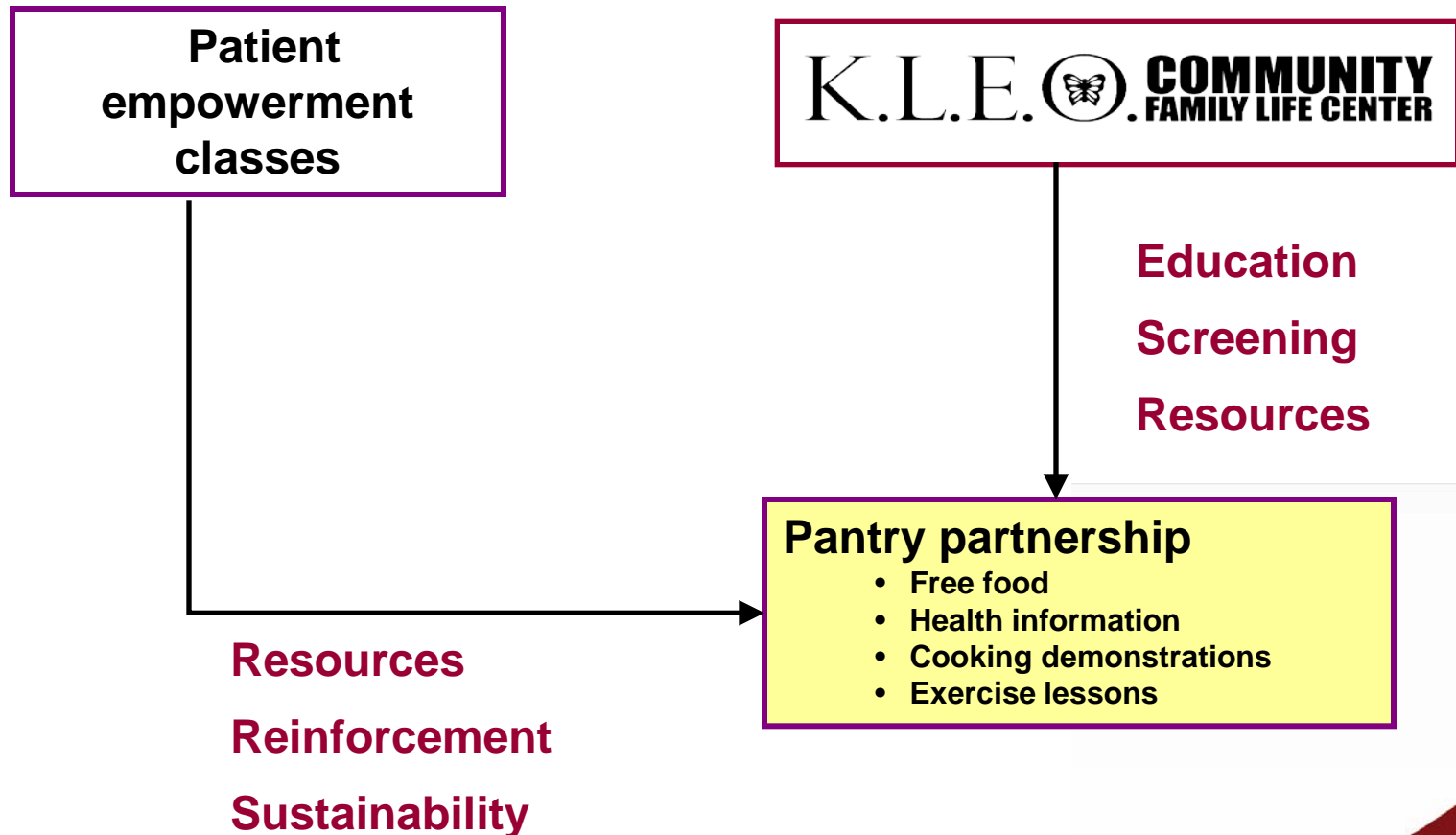
# Lessons Learned from Collaborative Efforts

- Start small and expand later
  - Identify champions
  - Find projects of mutual benefit
- 

# KLEO Food Pantry




# Patient Activation & Community Partnerships





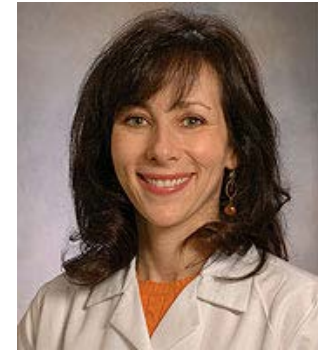


# Lessons Learned from Collaborative Efforts

- 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 **MAPSCorps** and **HealtheRx**

### Patients and Neighbors



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 **MAPSCorps**?

- It is an innovative youth employment program that trains local high school students to map businesses and organizations on the South Side of Chicago
- Youth gain hands-on field experience that prepares them for future jobs and higher education, especially in health, science, technology, engineering and math
- Data are available at [SouthSideHealth.org](http://SouthSideHealth.org) and [DondeEsta.org](http://DondeEsta.org) (Spanish)

### 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: Komred Holman, Friend Family, and Chicago Family
- 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 disease
- Patients and caregivers who use services on the **HealtheRx** also stimulate local business and help strengthen their communities

For more information call (773) 834-2356 or visit [www.healtheRx.org](http://www.healtheRx.org)

MAPSCorps and HealtheRx are innovations from CommunityRx, a flagship program of the South Side Health and Vitality Studies at the University of Chicago Medicine's Urban Health Initiative. CommunityRx is supported by grant #1C13MS000977-02-00 from the Department of Health and Human Services, Centers for Medicare and Medicaid Services. Its contents are solely the responsibility of the authors and have not been approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

### Local Health Providers

**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.

Doriane Miller, MD  
Associate Professor of Medicine  
Director, Center 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.

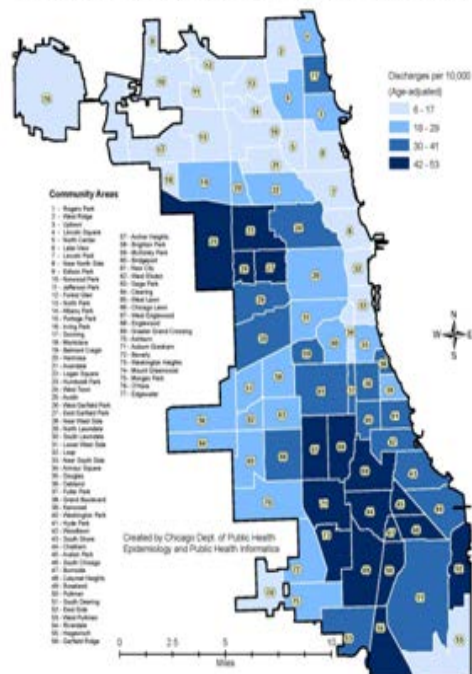
Tim Long, MD  
Physician, Komred Holman Health Center

Fill 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 disease. **HealtheRx** is the connection between health care and self-care.

Stacy Lindau, MD, MAPP  
Associate Professor of Obstetrics and Gynecology and Medicine-Genetics  
Project Director, CommunityRx


# Chicago Public Health Department

Imputed diabetes-with-complications hospitalizations per 10,000 residents (age-adjusted) by Chicago community area, 2010





# 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
- 



Robert Wood Johnson Foundation

Human Capital / Pioneer / Public Health

**Human Capital Blog**

Home Voices from the Field Nursing Emergency Care Health Burden of Stress

APR 27 2014

### How Can Health Systems Effectively Serve Minority Communities? Promote Health In Community Settings.

To mark National Minority Health Month, the Human Capital Blog asked several Robert Wood Johnson Foundation (RWJF) scholars to respond to questions about improving health care for all. In this post, **Monica E. Peek, MD, MPH**, assistant professor of medicine and associate director of the Chicago Center for Diabetes Translation Research at the University of Chicago, responds to the question, "What are the challenges, needs, or opportunities for health systems to effectively serve minority communities?" Peek is an alumna of the **Harold Amos Medical Faculty Development Program**.

With the health policy introduced by the Affordable Care Act, health systems have a unique opportunity (and admittedly, a challenge as well) to transform themselves in ways that promote health and not just treat illness. Such efforts are particularly relevant for racial/ethnic minorities, which disproportionately suffer from the morbidity and mortality of chronic diseases that are largely preventable in nature. Lifestyle changes (e.g. dietary patterns, physical activity,

**Kim Painter**  
National Minority Health Month  
April 2014

Comments: 13, 3, Tweet

Editor's Picks

- We See the Dead and Don't See the Living: The Realities of Black Men
- Diet Takes Toll on Health Study Finds
- Nursing Shortage Offset by Older Nurses Delaying Retirement
- Loneliness: A Significant Stressor that Requires Intervention

Updates on Twitter

Kim Painter @KimPainter

Retweeted By: RWJF News





**IMPROVING  
DIABETES**  
CARE AND OUTCOMES  
ON THE SOUTH SIDE OF  
**CHICAGO**



**Facebook.com/ImprovingDiabetes**



**Twitter.com/SSide\_Diabetes**



**Instagram.com/SSide\_Diabetes**




**YouTube.com/SouthSideDiabetes**



**Pinterest.com/SSideDiabetes**

# 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....





Peek ME, Wilkes AE, Roberson TS, Goddu AP, Nocon RS, Tang H, Quinn MT, Bordenave KK, Huang ES, Chin MH. Early lessons from an initiative on Chicago's south side to reduce disparities in diabetes care and outcomes. Health Aff. 2012; 31(1):177-86.

## COMMUNITY CASE STUDIES

By Monica E. Peek, Abigail E. Wilkes, Tonya S. Roberson, Anna P. Goddu, Robert S. Nocon, Hui Tang, Michael T. Quinn, Kristine K. Bordenave, Elbert S. Huang, and Marshall H. Chin

# 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.

**R**acial 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.<sup>4</sup> 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

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**Robert S. Nocon** is a health services researcher in the Section of General Internal Medicine, University of Chicago.

**Hui Tang** is a consultant at the Nielsen Company, in Chicago.

**Michael T. Quinn** is a senior research scientist in the Section of General Internal Medicine, University of Chicago.

**Kristine K. Bordenave** is a

# 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

