

NORTHWESTERN UNIVERSITY

Improving Health Outcomes Through Collaboration

Impact Assessment on Managing Metabolic Syndrome in the Austin Community of Chicago

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## ABSTRACT

### Improving Health Outcomes Through Collaboration

#### Impact Assessment on Managing Metabolic Syndrome in the Austin Community of Chicago

By Michael W. Diamond

Reducing the high incidence of metabolic syndrome especially among older people living in low income communities is a goal of the health system. Residents of the Austin community of Chicago suffer from a heavy burden of health issues related to metabolic syndrome leading to disproportionately higher morbidity and mortality rates from cardiovascular disease, diabetes, liver and renal disease. Health resources exist in this community, but limited access to qualified health information, accessible health related services and the failure to seek and find appropriate clinical services on a timely basis, adversely affect individual health outcomes. Collaborative community health-based partnerships have been found to improve health outcomes (Carrillo et al., 2011, pp. 1955-1964)

In 2012, the City of Chicago in collaboration with Loretto Hospital, the South Austin Community Coalition Council and the Austin Senior Satellite Center, initiated a weekly health education program to improve the health outcomes of seniors in the community. This study examines the impact of this collaborative effort on stress and hypertension of people over the age of 50 years, which are among the health issues related to metabolic syndrome and the ways in which the community members understand and manage their health.

The results indicate that this collaborative partnership reduces stress, helps to control hypertension and increases participants knowledge, understanding, awareness and ability to manage their health. The results also show the benefits of a safe, secure and supportive

environment in which the participants can socialize and receive qualified, culturally competent, health information and learn about appropriate, and affordable health services.

This study serves as a model for reducing and controlling metabolic syndrome by promoting increased collaboration among government, medical and other health providers, and community-based organizations that provide support for seniors.

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### **List of Abbreviations**

Accountable Care Organizations (ACO)

Adult Treatment Panel (ATP)

American Civil Liberties Union (ACLU)

American Heart Association – AHA

American Medical Association (AMA)

American Red Cross of Greater Chicago and Northern Illinois Adult and Pediatric Automated External Defibrillators/ Cardiopulmonary Resuscitation (AED/CPR)

Analysis of Variance (ANOVA)

Blood Pressure (BP)

Blood Pressure measurement expressed in milligrams of Mercury (mm/Hg)

Building a Healthier Austin - BHA

Building a Healthier Chicago – BHC

Chicago Asthma Consortium (CAC)

Chicago Department of Public Health (CDPH)

Chicago Public Schools (CPS)

Christ Tabernacle Missionary Baptist Church (CTMBC)

Community Health Information Centers (CHICS)

Contract Buyers League (CBL)

Coordinated Care Organizations (CCO)

Federal Housing Act (FHA)

Federally Qualified Health Centers (FQHC)

Health Information and Patient Protection Act (HIPAA)

Health Information Centers Utilizing Libraries in Evanston and Skokie (HIRCULES)

High Density Lipoproteins (HDL)

Hypothalamic Pituitary Adrenal Axis (HPA)

Institute of Medicine (IOM)

Metabolic Syndrome (MetS)

National Association for the Advancement of Colored People – NAACP  
National Cholesterol Education Program (NCEP)  
National Council of Black Nurses – NCBN  
National Diabetes Prevention Program (DPP)  
Northwestern University Community Health Corps (NU CHC)  
Northwestern University Community Volunteer Corps (CVC)  
Northwestern University International Program Development (IPD)  
Organization for Economic Cooperation and Development (OECD)  
Patient Protection and Affordable Care Act (PPACA)  
PCC Community Wellness Center (PCC) – Parent Child Center  
PCC Wellness (PCC)  
Real Estate Owned Properties (REO)  
Service Employees International Union (SEIU)  
South Austin Community Coalition Council (SACCC)  
Troubled Asset Recovery Program (TARP)  
United Nations High Commissioner for Refugees (UNHCR)  
United Nations International Children’s Fund (UNICEF)  
United Nations Office of the Coordinator of Humanitarian Affairs (UNOCHA)  
U.S. Centers for Disease Control and Prevention (CDC)  
U.S. Department of Health and Human Services (HHS)  
U.S. Department of Housing and Urban Development (HUD)  
U.S. Government National Mortgage Association (Ginnie Mae)  
U.S. National Center for Health Statistics (HCHS)  
U.S. National Health and Nutrition Examination Survey (NHANES)  
U.S. National Institutes of Health (NIH)  
Westside Alliance for a Safe and Toxic-Free Environment (W.A.S.T.E.)  
World Health Organization (WHO)  
Young Men’s Christian Association (YMCA)



## List of Key Organizations

Austin Senior Satellite Center

American Medical Association

American Red Cross of Greater Chicago and Northern Illinois

Asian Human Services Family Health Center

Chicago Public Library – Chinatown

Christ Tabernacle Missionary Baptist Church

Circle Family Healthcare Network

City of Chicago, Department of Family and Support Services

City of Chicago, Department of Public Health

Cook County Department of Health

Erie Family Health Centers

Evanston Department of Health and Human Services

Evanston Public Library

Global Polio Eradication Program: Rotary International, World Health Organization, UNICEF, U.S. Centers For Disease Control and Prevention

Illinois Department of Public Health

Loretto Hospital

PCC Community Wellness Center

Rush University Medical Center

Skokie Public Library

South Austin Community Coalition Council

U.S. Department of Health and Human Services, Region V

West Suburban Medical Center

Village of Skokie Health Department

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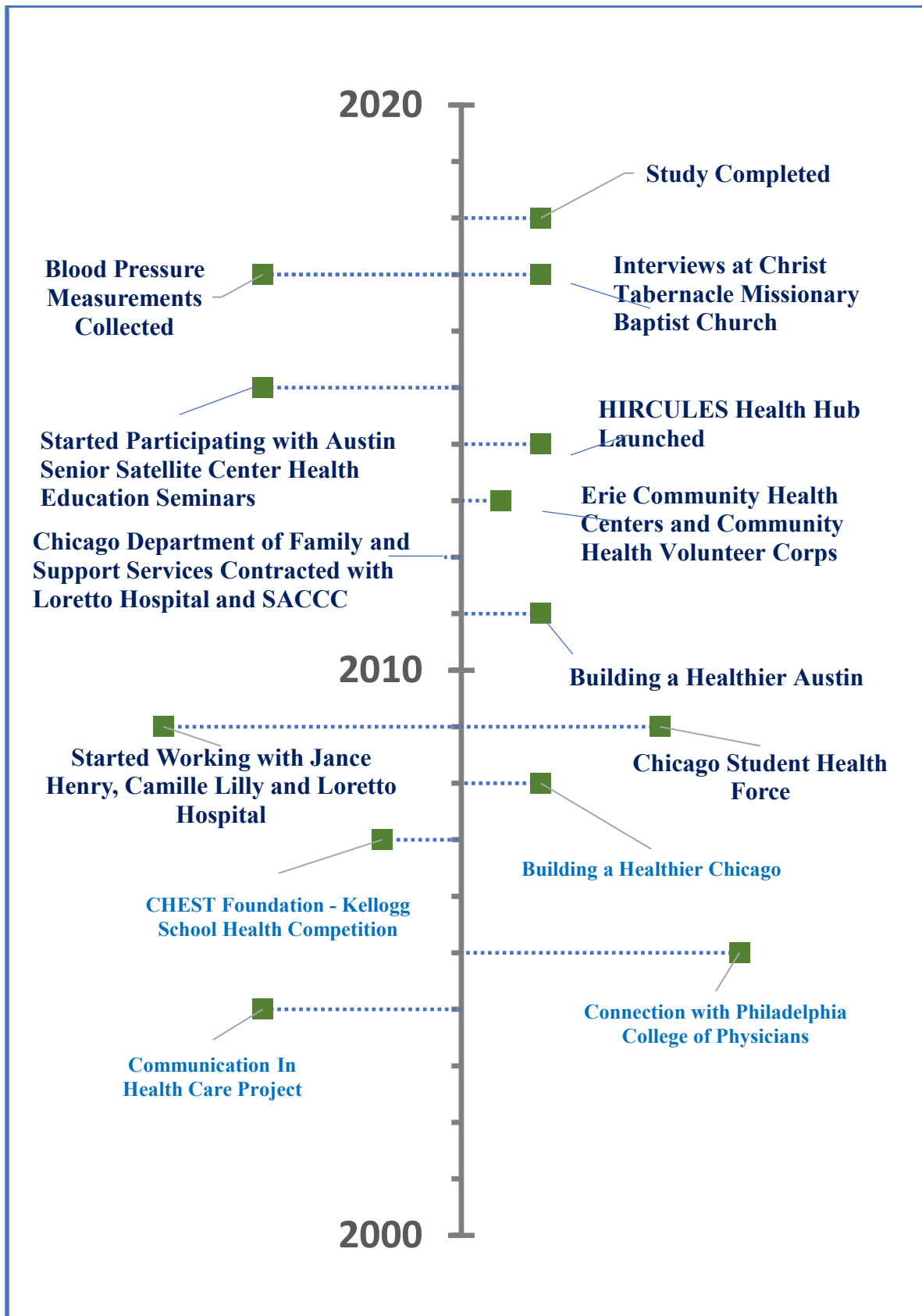
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### Timeline of Study in the Austin Community of Chicago 2004-2018

2018	Study Completed
2017	Blood Pressure Measurements Collected
2017	Interviews at Christ Tabernacle Missionary Baptist Church
2017	Started Interviews at Austin Senior Center
2015	Started Participating with Austin Senior Satellite Center Health Education Seminars
2014	HIRCULES Health Hub Launched
2013	Erie Community Health Centers and Community Health Volunteer Corps
2012	Chicago Department of Family and Support Services Contracted with Loretto Hospital and SACCC
2011	Building a Healthier Austin
2009	Started Working with Janice Henry, Camille Lilly and Loretto Hospital
2009	Chicago Student Health Force
2008	Building a Healthier Chicago
2007	CHEST Foundation - Kellogg School Health Competition
2005	Connection with Philadelphia College of Physicians
2004	Communication In Health Care Project Started



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## CHAPTER 1 INTRODUCTION

Despite recent advances in medical science and technology, the disparities in health outcomes among different populations around Chicago remain a major problem. There is a large and continuously growing body of data documenting the enormous adverse effects of health disparities, in terms of unnecessary suffering, premature death, and loss of human and financial capital and depletion of personal and national health care resources (Agency for Healthcare Research and Quality, 2011, 2017; CHEST, 1999, 2000; Groman & Ginsburg, 2004; Institute of Medicine, Smedley, Stith, & Nelson, 2002; LaVeist, 2009; Lavizzio-Mourey, 2004; Smedley, 2004). Although lack of access to insurance is a major factor limiting access to clinical services, it is not the only one and additional efforts are needed to bridge medicine, public health and personal health management (Hadley, 2003; Koh, 2011; Lurie & Dubowitz, 2007; Ware, 1996). Since the 2002 Report of the Institute of Medicine, greater attention to improving health outcomes has resulted in the national disparity rates decreasing (Agency for Healthcare Research and Quality, 2011, 2017; Institute of Medicine et al., 2002). However, in Chicago, disparities in fifteen of health status indicators, have increased over the last decade (Margellos, 2004; Orsi, 2009; Silva, 2001). In Chicago, “the City that works,” something is not working.

This analysis of health disparities and the need to strengthen health outcomes by improving the alignment of services with the strategies community members use to manage their health, is not new (see Ackermann, 2013; Carrillo et al., 2011; Hasnain-Wynia, 2001; Heiman & Artiga, 2015; Miller, Cunningham, & Ali, 2013; Perry, 2013). The increase in health disparities in Chicago has occurred in spite of efforts by public health programs, medical centers, academic institutions and community-based organizations to reverse these trends (Chicago Department of

Public Health, 2006, 2011). Chicago has a number of local neighborhood groups, civil society organizations, commercial health care organizations and government agencies currently providing health services in very creative ways that deal with remedying such inequities and which sponsor specific projects to correct problems arising from health care disparities (Beirne, Salem, & Ferguson, 2005; Yonek, 2011). Unfortunately, local service providers are too often swamped by the day-to-day needs of delivering urgent care with limited resources and are unable to become aware of and adopt some of the best practices of other groups providing similar type services or to collaborate in coordinated programs. Government and civil society organizations have multiple responsibilities that limit their opportunities to coordinate or develop new activities that could effectively reduce such disparities (Agency for Healthcare Research and Quality, 2011).

Furthermore, competent and dedicated individuals and organizations often work in relative isolation and their accomplishments, best practices and lessons learned could be more widely shared (Boone & Schwartzberg, 2010). Through increased alignment, coordination and sharing of resources, people living in resource challenged environments could have increased access to qualified health information and clinical services which could change the way in which they manage their health, improve health outcomes and reduce disparities. (Cohen, 2011; Derose, 2011; Gutierrez, Margellos-Anast, & Whitman, 2011; Lurie & Dubowitz, 2007; West & Whitman, 2011).

Residents of the Austin community manifest a high rate of chronic illness and suffer from a heavy burden of disease, including health issues related to metabolic syndrome (Chicago Department of Public Health, 2014; Yonek, 2011). Although the official 2010 census determined that there were about 98,000 people living in the community, some estimates place

the actual population at 120,000 to 180,000 (Paral, 2012). Until 2016 Austin had the largest population of any community in Chicago. Since then however, there has been a migration of people out of the Austin area and by 2016, the population was estimated at 87,600 to become the second largest populated community (Eltagouri, 2017). Of these, it was estimated that about half do not have health insurance, and it is not clear how many people are registered with Medicaid or Medicare. As a result, although there are clinical services available in the immediate and contiguous communities, large numbers of people use free services provided at community health fairs or wait until their health problems become catastrophic before seeking care in one of the emergency rooms of local hospitals (Adaji et al., 2018; Gates, 2012; Henry, 2012; Kinney, Lemon, Person, Pagoto, & Saczynski, 2015; Rocovich & Patel, 2012). This health management strategy is not helpful for the long-term health of the patient and is an extremely costly method of rendering care. By according the underinsured access to health insurance and primary care services through the ACA and providing exposure to both qualified health information and affordable clinical services in the community and changing the socio-ecological environment in which people live towards a healthier, wellness focused approach, people's health management strategies may be expected to change (Agency for Healthcare Research and Quality, 2017; Heiman & Artiga, 2015; Kinney et al., 2015; O'Malley, 2013).

### ***Background to the Study***

For the past ten years I have worked with community groups in the Austin community of Chicago. I was introduced to Austin through the Student Health Corps program with the Chicago Public Schools from 2009 to 2013. (Diamond, M. 2009; Slubowski, 2011). Michele Clark High School in the Austin community was involved from the beginning and became the focus of the program from 2010 to 2013. Because this was a collaborative program that involved

organizations from the public, private and civil society sectors I was introduced to over a hundred Austin community-based organizations and people and developed relationships with many of them. During this period, I became acutely aware of the many health issues that were challenging people in the community as well as the resources that were available to them and have long supported an asset-based approach to address community issues. (Kretzmann & McKnight, 1993).

There have been numerous organized attempts to promote population health in Austin and other Chicago communities, through coordinated community-based coalitions, wellness initiatives, and increased access to qualified health information and clinical services (Hasnain-Wynia, 2001; Salem, Hooberman, & Ramirez, 2005; U.S. Department of Health and Human Services, Office of the Regional Health Administrator Region V, & City of Chicago Department of Health, 2008). Many of these efforts depended upon external resources and have not been sustainable. A good example of this was the Healthy Chicago coalition created by the Chicago Department of Public Health in 2000. This initiative established four Healthy Chicago community partnerships: Healthy Albany Park, Healthy South Chicago, Healthy Chicago Lawn and Healthy Austin. This was an effective strategy to identify and build coalitions that provide health services to the people of these communities and serve as a resource center and facilitator (Chicago Partnership for Public Health, 2000; Yonek, 2011). All these coalitions depended on external resources for support and the last one, Healthy Albany Park, closed in 2010. With this understanding that self-sustaining local health coalitions and partnerships needed to be built and strengthened, Building a Healthier Chicago coalition was formed in 2008 (U.S. Department of Health and Human Services, Office of the Regional Health Administrator Region V, & Chicago Department of Public Health and the American Medical Association, 2008). This was a

collaborative initiative established by Health and Human Services Region V, the Chicago Department of Public Health and the American Medical Association. This coalition brought together over 800 organizations from the public, private and civil society sectors.

Because of my involvement with the Austin community I was asked by the U.S. Department of Health and Human Services Regional Director to lead a model project to Build a Healthier Austin from 2011-2013. The overall goals for Building a Healthier Austin were presented to and approved by the Executive Committee of Building a Healthier Chicago on 15 March 2012 (Diamond, M. 2012b). Building a Healthier Austin Inc. applied for incorporation and tax-exempt status in 2012 as a community led organization and the Westside Ministers Coalition had agreed to become the fiscal sponsor. This effort collapsed with the dissolution of the Building a Healthier Chicago coalition in 2012.

Working on these programs in Austin introduced me to several people who are community leaders. Janice Henry is the community health nurse at Loretto Hospital. In this capacity she provides services to patients in Loretto Hospital and is the liaison between Loretto and community and faith-based organizations. She is a recognized and respected community leader and has served on the boards of the American Heart Association, the National Council of Black Nurses, NAACP, Westside Ministers Coalition and many other groups. She was a founding member of the Healthy Austin Inc. coalition. She is the community health nurse at the Austin Senior Satellite Center. She works closely with Camille Lilly, who is the State Representative for Illinois District 78 which includes Austin. She is also the Chief External Affairs Officer/Development & Community Health for Loretto Hospital and is the President of the Austin Chamber of Commerce. Through Camille and Janice, Loretto Hospital organizes and supports community health fairs, and partners with other health serving organizations such as

PCC Wellness. Under Janice's sponsorship I have been able to provide Northwestern University undergraduate, graduate and medical students with opportunities to participate in these community health fairs and other community health initiatives.

Janice is a mentor. She has guided me in the planning and implementation of this dissertation study and made several important introductions. It was through her work with First Ladies Health Initiative and other community health fairs, that I met several of the leaders of the faith-based and community-based organizations in Austin. Further, Janice is very protective of the people and organizations she works with. She has deep concerns about the ways in which people and organizations external to Austin provide assistance or want to implement studies. She is also sensitive to the feelings, skepticism and sentiments of the Black and African-American population in the Austin community regarding their relationship with the established medical community and especially with an older white male (Washington, 2006).

One of her first questions to me, before helping on my study, was to ask what was I going to contribute to the health of the people of Austin. My response over the past three years was to participate in some of the weekly health education seminars at the Austin Senior Satellite Center. I organized students from my classes to participate in the First Ladies Health Initiative, the annual West Side Back to School Fairs, and other community health events by taking glucose and blood pressure measurements, helping with administration and providing fresh fruit to the youth and their families. Nevertheless, there were several seniors in the Austin Senior Satellite Center who refused to participate in the interviews with me or share their health data. They just did not want to be studied. And even though I became friendly with the pastors of several of the churches and faith-based community groups, was known to some of their members, and was always received warmly, there was a reluctance to participate in the study. This reluctance was

exacerbated due to three instances of gun violence on church properties with several fatalities. There was one church, the Christ Tabernacle Missionary Baptist Church which welcomed me and supported the study. I met the pastor and the First Lady of the church at the First Ladies Health Initiative which was held at another church the previous year. They asked one of their members, to look after me and to help organize the other members of the church. The pastor also invited me to one Sunday's services and gave me time to address the entire congregation at both services. This introduction to the congregation, with the clear support of the pastor and First Lady, sparked considerable interest among the congregants. I was invited to come each Sunday and conduct the interviews for a period of two hours after the service and could usually manage three interviews a session. During several Sundays they invited me to participate in their after service communal dinners. These were special events at which the food service was carefully organized and prepared by a group of dedicated parishioners and about 200 people from the church were served. I owe a special expression of thanks to Pastor David Ford, First Lady Constella White Ford, and Sister Wynn.

From the beginning of my work in Austin, it was clear that among the most important health issues facing all the people of Austin, are obesity, diabetes, cardiovascular disease, renal disease, homicides, cancers, and mental health (Chicago Department of Public Health, 2016b). It has also been determined that socio-ecological factors, social determinants or structural violence have a pronounced impact on stress and on each of these health issues. (Cai et al., 2017; Leatherman & Goodman, 1997; Papas et al., 2007; Slubowski Keenan-Devlin, 2014; Slubowski, 2010; Sweet, 2008; Zenk, Schulz, & Odoms-Young, 2009)

From three years of personal experiences as a participant/observer at the weekly health education seminars that were conducted by physicians and the community health nurse from



Loretto Hospital, I noted that these health education sessions provided access to trusted and qualified sources of health information and influenced the seniors who participated. When I learned that the weekly blood pressure measurements were being collected and stored over a period of five years, I realized I could analyze any changes or impact that their participation might have on hypertension, which is one of the five factors in a clinical diagnosis of Metabolic Syndrome. The community health nurse at Loretto was very helpful in obtaining permission to access these records. By setting up a study which involved interviews with two groups of participants at the Austin Senior Satellite Center and one group at the Christ Tabernacle Missionary Baptist Church, I could analyze the differences between those seniors who participated at the weekly health education programs, and the two other groups that did not.

Hence, the goal of this study is to examine the premise that people over the age of 50 years participating in a collaborative health education initiative will benefit from increased access to qualified health information and timely, affordable treatments associated with health issues related to metabolic syndrome. This study will also examine the impact of aligning individual health management strategies with appropriate access to qualified health information, and clinical health services and community support, provided by a community health organization. In particular, the study examines the impact of this public-civil society sector collaborative effort on stress and hypertension between these three groups of people over the age of 50 in the Austin community of Chicago.

In Chapter 2 this study examines the historical and ethnographic background of the Austin community from its beginnings to its current status. Chapter 3 looks at the relationship of structural violence and social determinants of health to health disparities in Austin and the implications for health issues related to Metabolic Syndrome. Chapter 4 describes and analyzes

the Methods and Approaches used in this study. In particular, I apply Anthropological methodology and the perspective of a collaborative framework to assess the impact of public, private and civil society sector collaboration, as an effective mechanism for designing and implementing programs to increase access to qualified health information and appropriate services which improve health, reduce disparities, and empower community members. The role of Anthropology as an analytical methodology and a catalyst which can empower people and organizations to improve the quality of their lives is explored in this chapter. Chapters 5 and 6 describe this study that was designed and implemented in the Austin community of Chicago to evaluate the impact of a collaborative health education program on people over the age of 50 years on their understanding and management of health issues related to metabolic syndrome. Chapter 5 presents the data from this study from a Qualitative or Ethnographic approach and includes descriptions and analyses of several other examples of community-based collaborations that have been organized in Chicago. Chapter 6 presents a Quantitative analysis of the impact by examining blood pressure measurements of participants in the collaborative program that relate to metabolic syndrome. Chapter 7 is the Conclusion in which the best practices, lessons learned and implications for further study are presented.

## **CHAPTER 2**

### **HISTORICAL/ETHNOGRAPHIC BACKGROUND ON THE AUSTIN COMMUNITY OF CHICAGO**

The Austin community of Chicago is part of Cook County in Illinois (See Appendix 1). Austin is one of the oldest communities in the city of Chicago (see Appendix 2) and is one of seventy-seven distinct Chicago communities (City of Chicago, 2018c). The area is bounded on the east by the Belt Railway (Hurd, 1952), just east of Cicero Avenue; on the south by Roosevelt Road from the Belt Railway, west to Austin Boulevard; on the north by the Milwaukee District/West Line railway (Metra Milwaukee District West, 2018) which runs north of North Avenue from the Belt Railway, west to Harlem Avenue (City of Chicago, 2018a). Austin is one of the oldest settlements in the city of Chicago. Early travelers to the region of Chicago in 1832 found the first Indian settlement in the area that is now Austin. They recorded five thousand native Americans who had collected near the village on lands that had been ceded to “white man”. These peoples were principally Potawatomi, Ottawas, Chippewas (Ochepewag), and “Kickapoos” or Miami (Danegger, 1944). The first legal title to the area was obtained by Henry DeKoven on June 25, 1835 (Danegger, 1944). These 280 acres were bounded by what is now Central Avenue on the east, Austin Boulevard on the west, the Chicago and Northwestern Railroad on the south and Augusta Boulevard on the north. Transportation was one of the key factors in the development of the Austin community.

Lake Street became the first stagecoach road from Chicago to Galena. Lake Street was not graded until 1842 and became the first fully planked road from Chicago to Oak Park by 1849. The Chicago Surface Line began operating electric cars on Lake Street in 1894 (Danegger, 1944, p. 10). The Galena and Chicago Union Railroad was chartered in 1836 and was

completed by 1848. Chicago's first locomotive ran ten miles to the Des Plaines River and returned with the first shipment of wheat to reach Chicago (Danegger, 1944, p.8). At that time, the Six Mile House tavern was built on Lake Street and became Austin's first depot for the Chicago and Northwestern Railroad in 1866 which later became the Chicago Metra Milwaukee District West Line (Metra Milwaukee District West, 2018). Starting in 1882, the Belt Railway Company of Chicago has become the largest intermediate switching terminal railroad in the United States. The Belt can now interchange with every railroad serving the Chicago railway hub. It has 28 miles of mainline route and more than 300 miles of switching tracks which includes the section of rail line that serves as the eastern border of the Austin community (Hurd, 1952). These transportation links through the Austin community provided access for shipments of coal and other ore, agricultural products, people and manufactured goods to and from Chicago and provided strong incentives to build commercial manufacturing, warehousing, and residential zones within and around Austin. In the 1960's, the Eisenhower Expressway 290 was built on the southern boundary, as part of the Interstate Highway system linking Chicago to Interstate 90 to Seattle. Access to the interstate highway system was a further incentive for manufacturing, warehousing, and residential development in Austin.

During this period, farmers from Cicero Corners, New York, settled into the six-mile square from Western Avenue (Chicago city limits) on the east, to Harlem Avenue on the west, and from North Avenue on the north to Thirty Ninth street on the south. They organized the Cicero Township government on June 23, 1857. This area includes the present communities of Cicero, Austin, Oak Park and Berwyn. By 1867, Cicero was incorporated as the Town of Cicero and was granted a special charter by the state assembly in 1869. On November 14, 1865, Henry W. Austin, a salesman for jack screws, which lifted buildings out of the mud, purchased

the 280 acres in Cicero Township that belonged to Henry DeKoven. This area was the central part from which the community of Austin developed and became the largest part of the Cicero Township. Due to political rivalries, especially with the village of Oak Park, the community of Austin was voted out of the township and annexed by Chicago in 1899. The final outrage was due to Austin's approval of the extension of the Lake Street Elevated system to Oak Park.

(Danegger, 1944) (Martin, 2004, p. 54).

Due to the transportation facilities, European immigrant groups, particularly Germans, Scandinavians, Irish, Italian and Greeks moved into Austin as a residential community. They brought with them their faith-based institutions, particularly Roman Catholic, but included Lutheran, Greek Orthodox and others. Austin Hospital was opened next to the Greek Orthodox Church in South Austin in 1923. The hospital was managed by a Lithuanian religious order, the Sisters of St. Casimir. It was later re-named as Loretto Hospital. It currently serves more than 33,000 patients yearly (Loretto, 2018).

By 1930, the residential population of Austin was 131,114, of which 130,932 were white (99.9%). There were 132 black residents and 50 others (Martin, 2005). Of these, 19.6% were foreign born, and 40.5% were native born with foreign parentage. By 1960 there were 125,133 residents of which 124,916 were white; 132 were black; and there were 186 people of other races. Of these, 14.4% were foreign born and 32.9% were native with foreign parentage. There was a rapid change in the demographic population from 1960 – 1990. During this time there was a massive migration of the white population out of Austin, and an influx of working, middle class black families looking to move into higher socio-economic areas. By 1990, there were 114,079 people in Austin. Of these, 12,211 were white; 99,046 were black; 177 were native American; 1,016 were Asian/Pacific Islanders, 1,629 were other races and 4,154 were of

Hispanic origin (Martin, 2005). By this time, there were only 3% foreign born. The Austin community is the largest geographical community of all seventy-seven Chicago communities. And until 2016 Austin had the largest population of any community in Chicago. According to the 2000 Census, there were 118,000 people officially living in Austin. And by 2016, for the first time in 45 years, with a population of 97,600, Austin became the second largest population behind the Lakeview community (Eltagouri, 2017). As will be seen in Chapter 3, from the 1960's, a variety of economic, political, social and environmental forces, including institutionalized legal policies served to eliminate the financial capital and force most of these working, middle class African-American families into poverty and to lose their jobs and their homes. These and other stressors such as violence have an impact on the health of the residents in the community and especially on health issues related to Metabolic Syndrome.

### CHAPTER 3 STRUCTURAL VIOLENCE AND METABOLIC SYNDROME

#### *Structural Violence*

When dealing with health issues that affect communities and population groups, bio-medical responses are often insufficient by themselves to resolve the issues and to identify the underlying factors that contribute to the disease, state of health and often compromise the effectiveness of medical science and systems to prevent or alleviate the problem. In the 1890's, Dr. Rudolph Virchow in Germany, was one of the first medical professionals to recognize the relationship of environmental conditions such as poor sanitation and water, overcrowding, poverty, air pollution and poor quality of foods to health issues such as Tuberculosis, cholera, plague, and other infectious diseases (Ackerknecht, 1953; Virchow, 1964). Marginalized people often suffer disproportionately from health issues than the hegemonic or more powerful social, cultural or economic community or population groups. Arthur Kleinman, Veena Das and Margaret Lock defined the term "Social Suffering" which:

"results from what political, economic, and institutional power does to people and reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman, Das, & Lock, 1997, p. ix).

Frequently in addressing the suffering, the responses often perpetuate the problem or maintain *status quo* rather than reducing the conditions which influence the issues in the first place. One of the champions of improving health outcomes, especially for marginalized, communities and population groups, Paul Farmer defined these conditions as "Structural Violence":

The term "structural violence" is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities). With few exceptions clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet, it has long been clear that many medical and public health interventions will fail if we are unable to understand

the social determinants of disease.( Farmer, P. E., Nizeye, Stulac, & Keshavjee, 2006, pp. e449-e450)

And

... neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress.” (Farmer, P., 1999, p. 79).

These formal and deliberate, social, political, economic and cultural arrangements are often referred to as the ways in which hegemonic forces control, oppress, and capitalize from the communities that they intentionally marginalize and exploit. Many anthropologists are concerned with these marginalized populations as they are often excluded from history, and frequently suffer from inequitable access to education, clean water, sanitation, safe and clean housing, employment, safe and clean environments, affordable and nutritious foods, safe energy, and qualified health information and services. (Biehl, 2007; Diamond, S., 1974; Farmer, P., 2003, 2004; Farmer, P., Kim, Kleinman, & Basilico, 2013; Kleinman et al., 1997; Rylko-Bauer & Farmer, 2016; Scheper-Hughes, 1993; J. Steward, Robert Manners, Eric Wolf, Elena Padilla Seda, Sidney Mintz, Raymond Scheele, 1956; Varma, 2008).

When organizations attempt to address humanitarian or health crises, there are two ways to respond. 1) External agencies can deliver services which provides immediate relief but often results in dependency. Or 2) an alternative approach which builds resilience through strengthening existing organizations and institutions, often referred to as sustainable development that empowers people to become more resilient and independent (Anderson & Woodrow, 1989). Social and economic development is a common goal for most people and communities. But structural violence is often an obstacle to such development for all people, especially marginalized ones (Sen, 1999). While this analytical framework is very descriptive,



applicable and creates an environment in which these barriers can be addressed directly, it also is viewed as controversial and confrontational (Frank, 1966; Gutiérrez, 1973; Polier & Roseberry, 1989; Roseberry, 1993). In 2001, Gro Harlem Brundtland, Director-General of the World Health Organization, initiated a less confrontational approach. She stated that

“Health is no longer a concern only of health professionals. A much wider constituency is engaged.” “Health has now moved to the heart of domestic and international development agendas. Good health is recognized as a prerequisite if communities are to be enabled to fight against poverty.” “Many of the major determinants of better health lie outside the health system. Such determinants include knowledge made available to people, clean environments, access to basic services, fair societies, fulfilled human rights, good government, enabling of people to make decisions relevant to their lives and to act on them.” (Brundtland, 2001, p. 96)

In 2005, WHO Director General Lee Jong-wook, established the Commission on Social Determinants of Health. In 2008, the Final Report of the Commission defined these as:

the structural determinants and conditions of daily life responsible for a major part of health inequities between and within countries. They include the distribution of power, income, goods and services, and the circumstances of people’s lives, such as their access to health care, schools and education; their conditions of work and leisure; and the state of their housing and environment. The term “social determinants” is thus shorthand for the social, political, economic, environmental and cultural factors that greatly affect health status. (World Health Organization, 2009, p. 1).

The WHO now defines the social determinants of health as the “conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries” (World Health Organization, n.d.). The WHO is currently focused on building and strengthening national health systems that include programs which address these social determinants in addition to the biomedical components. There are other synthetic approaches to health related to social, cultural, political, economic, religious, and

environmental factors. (Baer, 1996; Garrett, 1994; Goodman & Leatherman, 2001; Leatherman, 2001; Leatherman & Goodman, 1997).

By 2016, the leading indicators of health showed Austin as having some of the worst health in Chicago (see Table 2). These indicators are measured by community health assessments, city, county, state departments of health, and national health statistics included population characteristics, morbidity and mortality rates, leading causes of death and morbidity, social determinants of health, and modifiable or preventable health risks (Chicago Department of Public Health, 2012b, 2014, 2016a, 2016b; Chicago Department of Public Health, Healthy Chicago 2.0, n.d.; Cohen, 2011; Salem et al., 2005)

### ***Impact of Structural Violence in Austin***

As shown in Figure 1, the white population of Austin began to leave the community for the suburbs starting in the 1960's. Much of their concern was fostered by the promotion of fear of reduced housing values due to incoming middle-class black families. Because of Chicago's manufacturing and service boom from the 1890's, many blacks came to Chicago from the South seeking to escape from the exploitative system of sharecropping and looking for higher paying manufacturing and service jobs in northern cities like Chicago.

My great-grandfather was brought here when he was like 9 or 10 years old, from Africa....When I grew up, he had a very small farm, and it was a family...who kept his books for him, from the time, he was ah, given his freedom, from slavery, and ah, then his children, who would be 100 now or more, started to go to school and learn a little bit how to count. And when they did, he went to the them and said to them, my children know how to count now, no longer need you to do it for me. And so they took his life. He was riding, then, when he rode off on his horse, he had this horse...they took the pickup truck and run under it. That was when I was ten years old. (80)

When I got out of high school, it was still under Jim Crow, there was nothing I could do, except to become a hair dresser, or go to college to become a teacher. There was no money to go to college, to become a teacher, and I had older sisters, that was already established here. So, I joined them, First I got married. And I had one little daughter. And my husband wanted to keep on farming. And I wasn't goin to stay on the

farm, so, I came here with that little daughter, and I got two children. I was a teenager with my son. (I studied) business administration at Crane College (Now Malcolm X, City College). And while I was working at Zenith for ten years, I kept going to school and going to school. (80)

Although most of the available housing for blacks was in segregated communities on the south side of Chicago, by the 1960's there were a growing number of middle class black families who were looking to move out of the segregated communities and into more integrated and middle-class areas on the west side of the city, of which Lawndale and Austin presented prime opportunities. However, the incoming black population was subjected to a series of economic exploitations, including redlining and contract sales of real estate which depleted many financial and other resources (Satter, 2009). Because of these illegal practices, and other exploitative economic endeavors, Austin has become one of the poorest communities in the city of Chicago. Although Austin is the largest geographical community in Chicago, it is one of the most resource challenged with poor indicators in many areas of analysis, including health.

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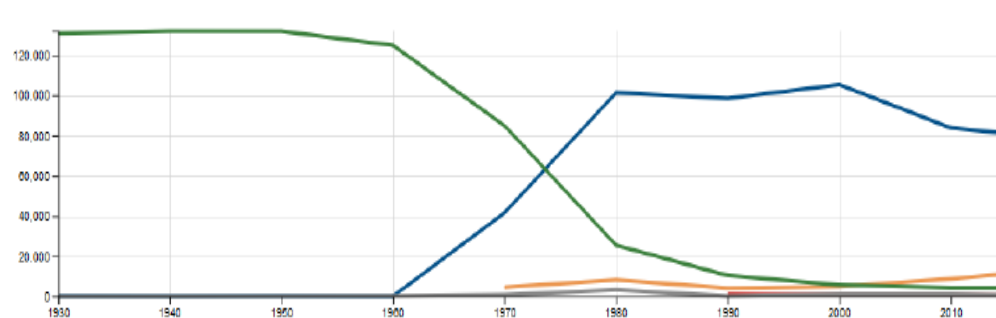
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### Community area demographics

Population by race/ethnicity, by decade

White Black Hispanic Asian Other

Austin



Source: Rob Paral and Associates <http://www.robparal.com/>

Figure 1 Transition of White to Black population in the Austin Community 1950 - 2010

As can be seen in Figure 1, from the 1950's, white families began to leave Austin for suburban communities. Black, middle class working families, began to move in and by the middle of the 1970's, they were the majority population group. White families leaving Austin sold their homes to speculators who were able to purchase the homes at fair market value and then sell them to aspiring black families at substantially higher prices under a practice of contract selling. Beryl Satter in her book Family Properties: How the Struggle Over Race and Real Estate Transformed Chicago and Urban America, described this practice in excruciating detail (Satter, 2009). From the 1950's contract selling was a common practice throughout the United States. As banks would "redline" a black neighborhood and withhold conventional mortgages from black families, unscrupulous speculators would sell these homes at greatly increased prices and offer contract mortgages as alternative financing. The speculators would retain ownership of the property until the entire mortgage was paid off. And if even one month's payment was missed, the speculator would repossess the house, evict the occupants, and retain all the payments and then resell the house to another aspiring black family. A speculator could purchase these houses from departing white families at a cost of \$3,000 and sell the house to a black family for \$13,000 with a contract mortgage. The practice of redlining communities was institutionalized in 1937 with the passage of the Federal Housing Act. Federal housing agencies physically marked areas that were deemed to receive preferential lending status by banks, insurance companies, savings and loan associations and other financial services companies with green shading, and intermediate areas with blue. Those areas that were determined to be unfit for such investments were marked in red. These zones were used by the financial services companies to withhold loans to homeowners who wanted to purchase houses in these areas or to provide financing at an exceptionally high cost (BlackPast.org, n.d.; Guttentag, 1980).

As a consequence of redlining, neighborhoods that local banks deemed unfit for investment were left underdeveloped or in disrepair. Attempts to improve these neighborhoods with even relatively small-scale business ventures were commonly obstructed by financial institutions that continued to label the underwriting as too risky or simply rejected them outright. When existing businesses collapsed, new ones were not allowed to replace them, often leaving entire blocks empty and crumbling. Consequently, African Americans in those neighborhoods were frequently limited in their access to banking, healthcare, retail merchandise, and even groceries. One notable exception to this was (and still is) the proliferation of liquor stores and bars which seemingly transcended the area's stigma of financial risk. (BlackPast.org, n.d.)

Satter described the practice of contract mortgages in redlined communities such as Austin in Chicago from 1956 – 1970 and explained how this practice wiped out the accumulated capital of middle class black working-class families and left underdeveloped communities in its wake. Often the costs of the homes and the interest rates were so high, that the black families had to try everything possible to increase their income and reduce costs so that they could pay the monthly contract fee. Everyone who could work sought employment. The families often subdivided their homes or partitioned them to accommodate renters. They postponed repairs and upgrades to the house which often resulted in significant reduction of the house value. Her father was a civil rights lawyer who tried to protect these homeowners from being evicted and losing their investment as well as their property. She estimated that 85% of all black home purchases during this period were made with contract mortgages (Satter, 2009, p. 4).

By 1968, this practice had become so commonplace that the residents targeted for evictions due to these contract mortgages (mostly from Lawndale) formed the Contract Buyers League (CBL). The CBL was an organized effort to file legal suits and protect these families from eviction. They picketed and protested against the contract sellers, and in addition to lawsuits to stop evictions, they promoted the renegotiation of the contracts. In many cases these renegotiations resulted in substantial savings. The West Side legal cases first went to trial in 1975, and the South Side case in 1979. Both cases were lost, and the last appeal was rejected in

1983 (Finley, 2016). The efforts of the Contract Buyers League and subsequent community organizations on the West Side were heavily influenced by the civil rights movement and especially the work of Dr. Martin Luther King in the North Lawndale neighborhood from 1966 (Finley, 2016).

Due to the impact of the civil rights movement, President Lyndon Johnson integrated the Federal Housing Authority into the newly established Cabinet position of Housing and Urban Development (HUD) in 1965. Following the assassination of Dr. Martin Luther King, the Civil Rights Act was passed in 1968. Also known as the Fair Housing Act its primary intent was to ban discrimination in housing. It also authorized HUD to enforce anti-discrimination laws and established the Government National Mortgage Association (Ginnie Mae) to provide mortgage funds for moderate income families using government guaranteed mortgage-backed securities (U.S. Department of Housing and Urban Development, 2018).

From 1968 – 1976 these FHA loans replaced contract mortgages. But even though they provided funding for the mortgages they were not without significant negative impact on the black home buyers. The FHA appraisers accepted bribes to substantially increase the value of the homes, even though there were major structural and cosmetic problems with the houses. These increased values allowed the sellers to set the prices of the homes at significantly higher levels, but with low down payments. These low interest federally guaranteed loans were attractive to the middle-class black families as they qualified for the loans. But due to the very high cost of the houses and the substantial funding that was necessary to repair and rehab the houses, many of these home buyers also fell behind in their payments, and the homes were foreclosed (Satter, 2009). The CBL and other Austin community organizations sued the Federal Housing Authority for its unscrupulous appraisal practices, and its foreclosures, but they also lost their case in 1976.

The pattern of low cost loans was repeated starting in the 1990's. The largest sub-prime lender was Countrywide mortgages. Between 1993 and 1994, it increased its loans to African-American borrowers by 363% (Bruck, 2009, p. 7). These loans were guaranteed by FHA Fannie Mae loans. When the Federal Reserve Bank reduced its prime lending rates in 2001, Wall Street investors began to supplant Fannie Mae. This pattern of providing high interest loans to African-American and many other sub-prime borrowers resulted, not only in the default and foreclosing on many of these borrowers' homes, but also in the collapse of the national economy in 2007 (Bruck, 2009, p. 18). The impact of these foreclosures continues to the present time. Between 2009 and 2011 more than 73,000 homes in the greater Chicago area were foreclosed and as 93% of these could not be sold, ownership was retained by the lending institutions calling these properties Real Estate Owned (REO).

The Woodstock Institute examined the vacant property problem in the City of Chicago to evaluate its seriousness to the safety and livability of Chicago neighborhoods. They estimated that 64% of all of the Chicago REOs were in African-American neighborhoods, like Austin and that it costs the City of Chicago \$36 million to maintain and process the "red flag" properties "where mortgage servicers have started the foreclosure process and then decided not to complete it in order to avoid taking on the responsibility of maintaining and securing the home. (Rand, 2012). Figure 2. shows the distribution of these vacant and red flag properties in Chicago in 2010. These foreclosed properties frequently became abandoned and these increased levels of vacancy were associated with increased risk of violence, especially aggravated assault (Branas, Rubin, & Guo, 2012) . These properties are often occupied by gangs, drug addicts, used for prostitution, random shootings, and kidnapping. From 2016, Aldermen and community organizations such as the ACLU in Chicago's Austin community have proposed legislation to

the Chicago City Council to amend the City Nuisance Property Ordinance. They proposed requiring the banks or other owners of these abandoned properties to be responsible for securing the property against trespassers and protecting the community from illegal activities in these properties. These proposals were rejected by the Chicago City Council as placing too much financial burden on the owners.

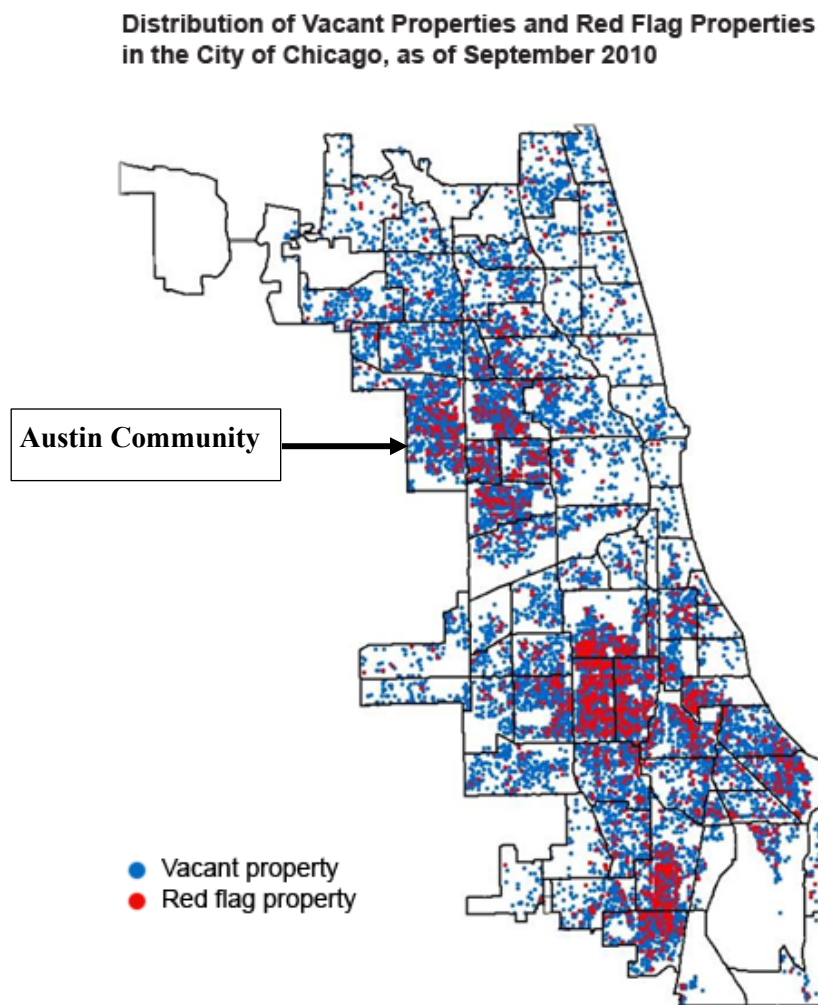


Figure 2 Foreclosed, abandoned, and properties flagged as dangerous, Chicago, 2010, Woodstock Institute, (Rand, 2012)

One of the latest examples of external exploitation of properties and community resources in the Austin community relates to an effort to repurpose the closed CPS Robert



Emmet Elementary School and create a community health and wellness center. The \$20 million development efforts were led by a developer, Rob Ferrino, with the support of local area health centers including, Cook County Health and Hospital System, the PCC Community Wellness Center, and the Mt. Sinai Health System, and with the support of the 29<sup>th</sup> Ward Alderman, Chris Taliaferro. There was no consultation or discussion with any of the health serving organizations or other community groups in Austin. The property was to be purchased from the Chicago Public Schools at a concessionary price of \$75,000, and the Health and Wellness Center would include a Health clinic, a dental clinic, specialized health services, and food services. The community was presented with this plan at a community meeting in July 2017, after all the details had been finalized. The community, including the Austin Chamber of Commerce and the SACCC was outraged. Their concern was the lack of engagement with community members and organizations. There were no public, open discussions about the planning for this new center and no discussions were held with the neighborhood Loretto Hospital, Circle Family Care, Hartgrove Hospital, or any of the local black-owned professional medical providers or other services such as day care centers, dentists and restaurants who have been serving the area for many years (Truss, 2017). At the community meeting, Lillian Drummond stood up and shouted, “Are you crazy?” She protested the lack of open discussion and community engagement in the process and put her concerns more bluntly “We know what this is all about. This is a money grab for Medicare.” (Dean, 2017). Janice Henry, the Community Health Nurse at Loretto Hospital stated that “the services being proposed for the campus are already being provided by her hospital and other health facilities in the area. Henry and other residents said the site can serve other community needs, such as affordable housing or something for youth (Dean, 2017). This community concern reflects a long “historical breakdown in trust between potential developers

and community members on the West Side” (Studenkov, 2017). Another community leader was quoted as saying: "There's a lot of distrust because there's been manipulation that's been put on in our community," said Rev. Griff Taylor, pastor of New Sounding Joy Ministries” (Studenkov, 2017). As a direct result of this protest, the development effort was discontinued. Efforts are now being discussed to convert the facility in to a youth center (Belsha, 2017; Dean, 2017). The most recent transaction took place in March 2018, when the West Side Health Authority purchased the building, and will apply TIF funding for the refurbishment and renovation of the building. They are still planning for the use of the building (Studenkov, 2018). This last iteration of control over the use of this community asset is important as the West Side Health Authority is an Austin community-based organization and hopefully they will encourage community dialogue and engagement in the planning and implementation of the new facility.

These are some examples of the social determinants and structural violence that has been affecting the lives of the people living in the Austin community. These stressors have a profound impact on their health and the consequences can be noticed particularly with issues related to Metabolic Syndrome.

### ***The Metabolic Syndrome***

The Metabolic Syndrome (MetS) is a diagnosis which identifies people with a cluster of increased risk factors that doubles the risk of developing cardiovascular disease or for patients without diabetes, increases their risk for diabetes mellitus type 2 by five times (Grundy, 2016; Kaur, 2014). Individuals with MetS are 2 to 4 times more likely to have a stroke, a 3 to 4 times increased risk of myocardial infarction and double the risk of dying from such an event compared with those without the syndrome, regardless of a previous history of cardiovascular events (Kaur, 2014). Table 1 presents the clinical criteria for identifying the MetS, as defined by

the National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) (Grundy, 2016). These guidelines define MetS based on cutoffs for five key risk factors: Abdominal obesity (waist circumference; cm), fasting plasma levels of triglycerides (mg/dL), high density lipoproteins cholesterol (HDL-C; mg/dL), blood pressure (mmHg), and glucose (mg/dL).

Table 1 Criteria for defining the Metabolic Syndrome based on the National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) Guidelines

Risk Factor	Defining Level
1. Abdominal Obesity, given as waist circumference *†‡	
Men	> 102 cm (>40 inches)
Women	> 88 cm (>35 inches)
2. Triglycerides	≥ 150 mg/dl
3. HDL cholesterol	
Men	< 40 mg/dl
Women	< 50 mg/dl
4. Blood Pressure	≥ 140/ ≥ 90 mm Hg **
5. Fasting glucose	≥ 100 mg/dl ‡
<p>*Overweight and obesity are associated with insulin resistance and the metabolic syndrome. However, the presence of abdominal obesity is more highly correlated with the metabolic risk factors than is an elevated BMI. Therefore, the simple measure of waist circumference is recommended to identify the body weight component of the metabolic syndrome.</p> <p>†Some male patients can develop multiple metabolic risk factors when the waist circumference is only marginally increased, e.g. 94 to 102 cm (37 to 39 in). Such patients may have a strong genetic contribution to insulin resistance. They should benefit from changes in life habits, similarly to men with categorical increases in waist circumference (Whelton et al., 2018).</p> <p>** In October 2017, the American Heart Association changed the criteria for Hypertension to: Hypertension Stage 1: 130-139 mm Hg systolic or 80-89 mm Hg diastolic; and Hypertension Stage 2: ≥ 140 mm Hg systolic or ≥ 90 mm Hg diastolic, based on an average of ≥ 2 readings obtained on ≥ 2 occasions.</p>	

‡ The American Diabetes Association has recently established a cutpoint of  $\geq 100$  mg/dl, above which persons have either prediabetes (impaired fasting glucose) or diabetes. This new cutpoint should be applicable for identifying the lower boundary to define an elevated glucose as one criterion for the Metabolic Syndrome.

(Grundy, 2016, p. 435).

If a patient presents with three or more of these risk factors, a diagnosis of metabolic syndrome can be made (Ervin, 2009; Grundy, 2016; Grundy, Brewer, Cleeman, Smith, & Lenfant, 2004). Since the prevalence of coronary heart disease and uncontrolled diabetes among people in Austin are among the highest rates of any community in Chicago, this research will study people's understanding of the underlying risk factors and evaluate programs designed to reduce them. Modifying lifestyle behaviors through education, weight reduction, diet, physical activity, behavior therapy and medication have been demonstrated to provide the most significant benefits (Grundy, 2016, pp 367-369; Grundy et al., 2004; Kaur, 2014; Knowler, 2002). Although there are health resources in Austin, people's access to such education, health information, nutritious foods, meditation activities, clinical services and medication is limited.

Each of the component risk factors of the Metabolic Syndrome is sensitive to a variety of influences. Obesity is one of the leading indicators as measured by abdominal waist size, and often influences liver functions, insulin resistance, and cholesterol levels and blood pressure. Waist circumference is a more accurate measure of abdominal adiposity than using Body Mass Index (BMI) calculations. While changes in lifestyle, through education, weight reduction program, diet, increased physical activity have demonstrable effects on reducing these risk factors, people's access to these changes is not always within their control. Some of the environmental conditions in which people live preclude their ability to address their own health issues (K. McLeroy, Norton, Kegler, Burdine, & Sumaya, 2003; K. R. McLeroy, Bibeau, Steckler, & Glanz, 1988; Merzel & D'Afflitti, 2003). The evidence of these relationships led to

the definition of Obesogenic environments and explains how these environments are affected by socio-ecological factors such as structural violence that provokes increased levels of stress (Leonard & Ulijaszek, 2002; Ulijaszek, 2017).

Previous research in Chicago has documented the multiple pathways through which conditions of poverty, marginalization and structural violence influence metabolic health. Emily Mendenhall worked with late adult first and second-generation Mexican immigrant women living with type 2 diabetes who sought diabetes care at a safety-net hospital in Chicago. Through her interviews with these obese and diabetic women, she found that trauma strongly influences risks for obesity and diabetes (Mendenhall, 2012b). Indeed, 70% of these women had been sexually or physically abused by a member of their family growing up in Mexico and had no one to talk to about the abuse. When they migrated to Chicago, they still had no one to help them deal with this trauma. Despite the medical providers instructing them to learn how to eat healthier, to purchase healthier foods, and to cook in a healthy way, they were not able to control their weight. Mendenhall realized that the women had an eating disorder as a result of their traumatic experiences. Further, the abrupt and condescending manner in which the medical professionals addressed these women had further disempowering impact (Mendenhall, 2012b).

Elizabeth Sweet (2008) examined the relationship between an individual's cultural experiences of stress and racial health inequalities. Using biocultural anthropological methods, she measured stress on African American adolescents in the Maywood community of Illinois. She assessed the impact that the hormone cortisol has on emotional and cardiovascular health as well as obesity and diabetes type 2 among these African American youth. Her study demonstrates the impact that social and cultural influences can have on stress which in turn manifests in increased health risks (Sweet, 2008).

Lauren Slubowski Keenan-Devlin (2014) examined the relationship of structural violence, stress, metabolism, nutritional health, and health behavior on Black youth on the west side of Chicago. She focused on the Hypothalamic Pituitary Adrenal (HPA) Axis, which “plays a key role in the immediate and long term adjustment to “stressors” of various kinds” (Slubowski Keenan-Devlin, 2014, p. 34) In a reaction to an acute stressor such as a physical or emotional threat, the body releases a series of hormones such as Corticotrophin Releasing Hormone, Adrenocorticotrophic Hormone, peptide and steroidal hormones, and Epinephrine to stimulate the sympathetic nervous system which increases heart rate, blood pressure and breathing rate. This reaction also provokes the production of Glucocorticoids (steroid hormones), one of which is cortisol (Slubowski Keenan-Devlin, 2014, p. 32). Cortisol stimulates the release of glucose and insulin in response to these acute stressors. This helps to prepare the body for response to the threats by storing fat, especially around the lower abdomen which in turn provokes insulin resistance and promotes the development of metabolic syndrome. (Tsigos & Chrousos, 2006). This increased adiposity helps to protect and prepare the individual against future stressors.

People will react to the environment in which they live. When this environment produces constant stressors, their bodies allocate energy resources in response to these external factors (Leonard & Ulijaszek, 2002). This energy balance model of obesity has profound implications for the medical, public health and economic response to obesity. Genetics, environment, social determinants such as access to water, housing, education, food, markets, clean air, violence, poverty, influence the ways in which people’s metabolism reacts through these energy balance susceptibilities, and results in energy intake exceeding energy expenditures. These obesogenic environments create a cycle where stressors provoke hypercortisolemia which contributes to adipocyte accumulation, feeding into insulin resistance, low grade inflammation, and the

development of metabolic syndrome and its health-related issues (Tsigos & Chrousos, 2006; Ulijaszek, 2017).

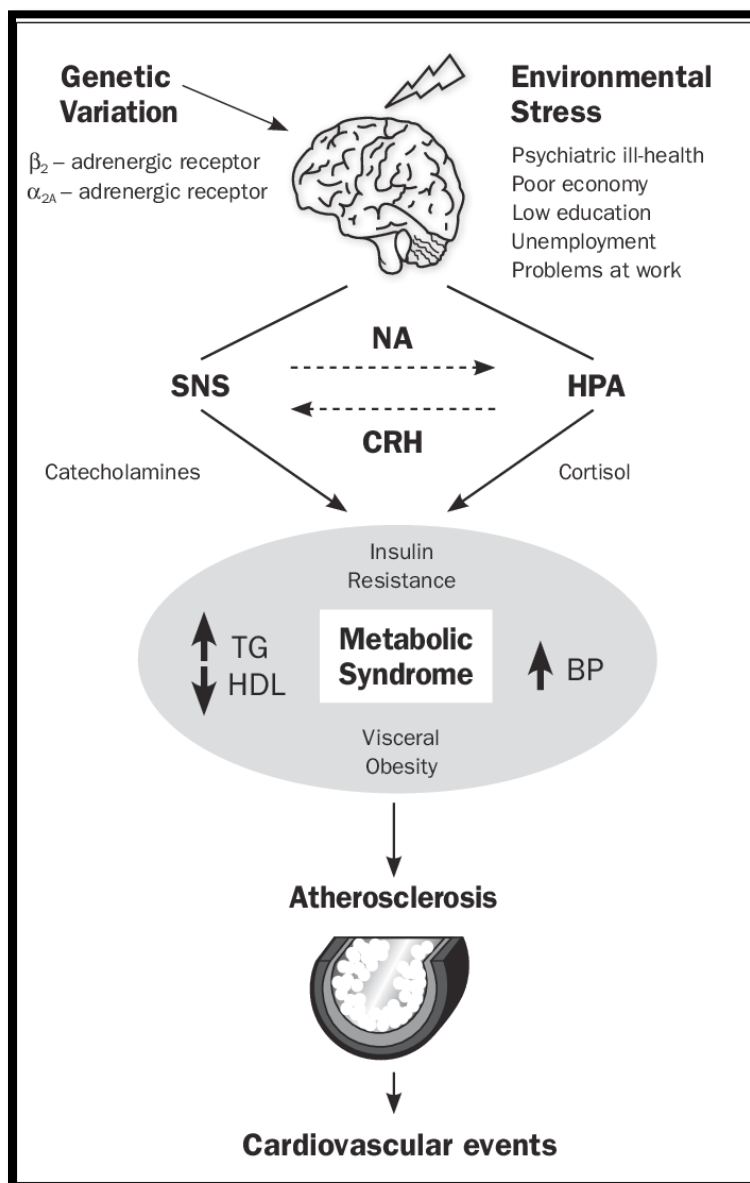


Figure 3 Relationship of Stress and Metabolic Syndrome

The Austin community of Chicago is an obesogenic environment, full of daily stressors. These include homicides, gun violence, gang violence, inadequate housing options, congested traffic patterns, drugs, alcohol, physical and sexual abuse, lack of employment opportunities,

food desert, racial prejudice, lack of affordable health care facilities, lack of safe streets and parks, and lack of easy access to low cost fast food options.

### ***Health Resources in Austin***

There are several layers of health resources which are available to Austin community residents. Because of the recent shift in August 2011, by the Chicago Department of Public Health to utilize the services of Federally Qualified Health Centers (FQHC) for all clinical services in Chicago, there are several FQHC's located within the Austin Community. These include: Access Community Health Centers, PCC Wellness Centers, Circle Family Health Clinics, Loretto Hospital, West Suburban Hospital and Access Bethany Health Center. Cook County Health Department supports the Austin Cook County Clinic which also houses the Westside Health Authority. There is only one hospital center, Loretto Hospital, which is physically located in Austin. There are four other hospitals in surrounding communities which provide services: West Suburban Hospital, Mt. Sinai Hospital, Rush Medical Center, Cook County Hospital. There are several community and faith based non-profit, organizations which provide health services to the local community. These include: Circle Family Health Centers, PCC Wellness Centers, West Side Health Authority, West Side Ministers Coalition, Peace Corner Youth Center, Austin Coming Together, Building a Healthier Austin and Health Committees within several local churches. These resources can now be located on a health asset map prepared by Healthy Chicago 2.0 (Chicago Department of Public Health, Healthy Chicago 2.0, 2018) There have been several efforts over the past decade to launch health coalitions in the community, all of which have collapsed due to lack of external funding. There have been considerable efforts to form such a coalition or coalitions and Building A Healthier Chicago was working with several of these from 2008- 2012. These include: Building a Healthier Austin,



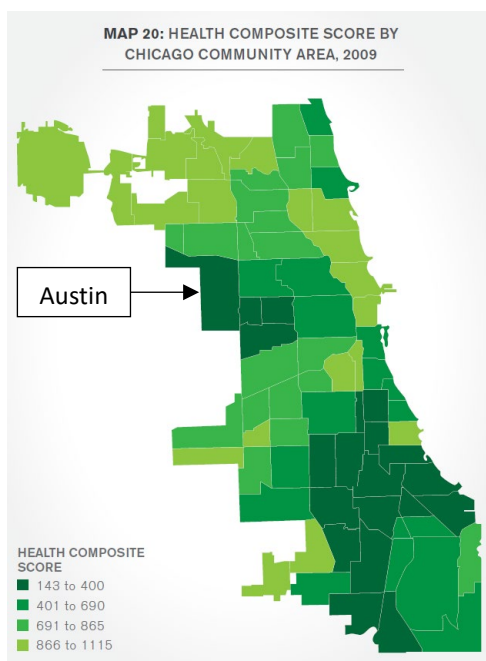
West Side Health Authority, West Side Ministers Coalition, Austin Coming Together, Healthy Austin, and Organization for a Better Austin. The Patient Protection and Affordable Care Act (PPACA) provides renewed support and promotion for such coalition-based wellness and health initiatives. With the implementation of the Illinois Health Insurance Marketplace that was launched in October 2013, there was increased funding and incentives for coordination of health promotion efforts. For the first four years of the PPACA Health Insurance Navigators were hired and trained through special funding channeled through the State of Illinois and assigned to work at Federally Qualified Health Centers, Hospitals and Accountable Care Organizations as well as public libraries. By 2016, funding from the PPACA for these Navigators stopped and had to be covered by the health care institutions themselves. Each of these health serving organizations in Austin and the surrounding communities, has a distinct vision, mission, objectives, programs and structure and often competes for funding and other resources. As a result, it has become more difficult to find health insurance options and receive the necessary assistance to apply. And as we have seen in the recent effort by neighboring hospitals to create a new community health and wellness center in the CPS Emmet Elementary School building, there is interest in providing services to the community, without engaging with the community. These events add stress to the people living in the community which further exacerbates their health problems and has direct impact on their health issues related to metabolic syndrome. By looking at the measurements of these issues, we can see the impact on the people's health.

There are many other indicators for measuring social determinants that impact the health of the community. These include: poverty or socioeconomic status, education, employment, food deserts, housing, transportation, mental health, childcare, and other services. Both Loretto Hospital and the City of Chicago Department of Health assess these indicators and develop their

Health service plans to address them (Chicago Department of Public Health, Healthy Chicago 2.0, 2018; Metropolitan Chicago Healthcare Council, 2015).

### ***Health Disparities in Austin***

Figure 4 is the City of Chicago Department of Public Health 2009 Community Area Health Composite which shows the cumulative rank of selected health indicators by each of the 77 Chicago communities. The health indicators included in this composite analysis are: Mortality data (influenza and pneumonia, coronary heart disease, homicides, all cancer, diabetes, breast cancer), Morbidity data (AIDS diagnosis, HIV infection diagnosis, gonorrhea, chlamydia, syphilis, elevated blood lead levels) and Natality data (prematurity, low birth weight, prenatal care in the first trimester, infant mortality rate, teen births) of the total rankings for each of Chicago communities. The Austin community is one of the Chicago communities with the lowest composite rank and has among the poorest health outcomes in Chicago.



## Health Composite Score



(Chicago Department of Public Health, 2012a, pp. 32-33)

Figure 4 Community Area Health Composite Score By Chicago Community, 2009

Table 2 provides data extracted from the City of Chicago dataset of the cumulative numbers of deaths annually, the adjusted death rates with corresponding 95% (Chicago Department of Public Health, 2012a) confidence intervals, and average annual years of potential life lost per 100,000 residents aged 75 and younger due to selected causes of death by Chicago community for the years 2006-2010 (Chicago Department of Public Health, 2014). A ranking for each measure is provided with the highest value indicated with a ranking of 1. The Austin community of Chicago ranks number 1 in the city of Chicago for almost all causes of death. By examining selected underlying causes of death in Austin from 2006 to 2010, several of these indicators are associated with violence and metabolic syndrome.

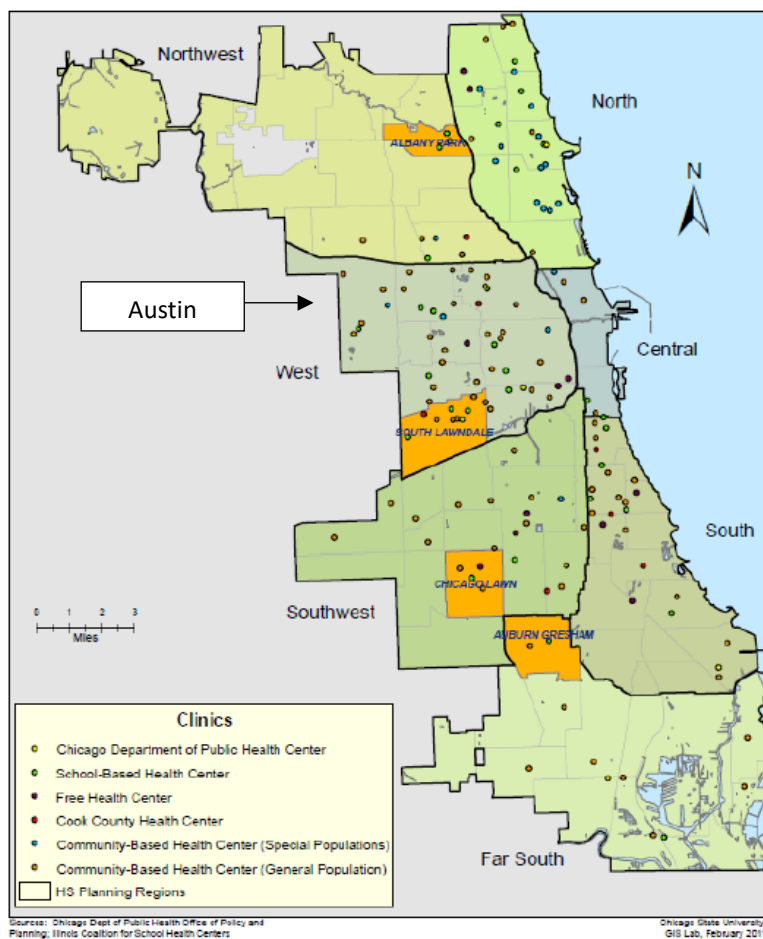
Table 2 Selected underlying causes of death in the City of Chicago 2006 – 2010 Austin Community

Cause of Death	Cumulative Deaths 2006 - 2010	Cumulative Deaths Rank	Average Adjusted Rate Upper CI	Average Annual Years of Potential Life Lost (YPLL) Rate 2006 - 2010
All causes in males	2475	1	1454.4	19342
All causes in females	2159	1	900.9	9779
Assault (homicide)	182	1	40.1	1699
Breast cancer in females	85	1	39.6	480
Cancer (all sites)	1143	1	270	2537
Coronary heart disease	679	1	180.4	1188
Diabetes-related	151	1	41.3	273
Firearm-related	158	1	34.8	1541
Injury, unintentional	222	1	52.8	1502
Kidney disease (nephritis, nephrotic syndrome and nephrosis)	120	1	34.6	220
Lung cancer	331	1	77.6	756
Liver disease and cirrhosis	42	4	11.3	163
Stroke (cerebrovascular disease)	226	1	64.7	430

(Chicago Department of Public Health, 2014)

Of interest to this study are the indicators for Assault, Coronary Heart Disease, Diabetes-related deaths, Firearm-related deaths, Kidney Disease, Stroke (cerebrovascular disease), and Liver Disease and cirrhosis which is ranked 4<sup>th</sup>. For almost all these causes of death Austin ranks the highest among Chicago communities.

With regard to health resources in Austin, there are more than 3,000 persons per physician in the Austin community which is a very low ratio (Yonek, 2011, p. 93). According to the 2018 report of the Organization for Economic Cooperation and Development (OECD), there were an average 2.6 physicians per 1,000 people in the United States in 2016. In a healthy U.S. community, there would be an average of 7.8 physicians for 3,000 people. (Organization for Economic Cooperation and Development, n.d.). There are six health clinics in Austin (Yonek, 2011, p. 91). Although there are several general acute care hospitals in the surrounding communities, there is only one adult acute care facility in Austin (Yonek, 2011, p. 92). As we will see, while there are health resources in the Austin community and in the surrounding communities, knowledge of the services and their locations is limited, the costs of these services can be expensive, and the hours of operation are sometimes limited.



A Profile of Health and Health Resources within Chicago's 77 Communities. Northwestern University Feinberg School of Medicine, Center for Healthcare Equity/Institute for Healthcare Studies, 2011.

(Yonek, 2011, p. 91)

Figure 5 Citywide Maps, Chicago Primary Care Clinics

Another indicator of the impact of uncontrolled diabetes on the population of Austin is the number of Diabetes Related Lower Extremity Amputation Hospitalizations in Table 3. According to the Discharge Data, Division of Patient Safety and Quality, Illinois Department of Public Health in 2014, the age adjusted rates for inpatient hospital stays for diabetes related amputation in Austin were among the highest in the city with an average rate of 1.93 per 10,000 people compared with the rate of 1.8/10,000 people for the City of Chicago and 2.1/10,000 African American or Black population. Two Austin Zip Codes 60639 and 60707 which have a

lower incidence rate are in the far north of Austin mostly in other communities of Belmont Cragin and Elmwood Park (Chicago Department of Public Health, Healthy Chicago 2.0, n.d.).

Table 3 Diabetes-Related Lower Extremity Amputation Hospitalizations, Chicago and Austin

Chicago Department of Public Health 2014			
Diabetes-related lower extremity amputation hospitalizations			
Inpatient Hospital Stay for Diabetes Related Amputation			
Race/Ethnicity		Number	Rate/10,000 Population
	Chicago	451	1.8
	Hispanic or Latino	71	1.8
	Non-Hispanic Asian or Pacific Islander	7	0.6
	Non-Hispanic African American or Black	197	2.1
	Non-Hispanic White	64	0.7
Age	45-64	204	3.4
	65-74	121	8.0
	75+	94	7.4
Austin		44	1.93
	Zip Code 60639	12	1.6
	Zip Code 60644	11	2.3
	Zip Code 606451	14	2.3
	Zip Codes 60707 and 60635	7	1.5

(Chicago Department of Public Health, Healthy Chicago 2.0, n.d.)

These statistics demonstrate that for selected indicators of health issues related to metabolic syndrome in the Austin community, the population suffers from a higher burden of disease, the highest mortality rates and a higher rate of diabetes related amputations compared to the rest of the city of Chicago even though health resources are available in the community.

## CHAPTER 4 METHODS AND APPROACHES

### *Anthropological methods*

Health deals with issues of biological disease and medical response, and with such human constructs as culture, ecology, politics, religious values, social networks, and behavior (Wood, 1979). Health providers frequently deal with issues of politics, and coordinate with the people of a community to gain acceptance for their health program. They must consider cultural issues and resources not only in terms of providing medication, but in terms of empowering people to access qualified health information and services. Furthermore, health is closely interrelated with social determinants of disease (World Health Organization, n.d.). Often improving the health condition of a community requires corresponding improvement of the ecological conditions which impact the social determinants of health. For example, human settlement patterns or changes in local ecology could be the underlying reason for an outbreak of meningitis in a local community, due to urbanization creating squalid living conditions (Garrett, 1994, pp. 59-66). Another example is the polio immunization program in Nigeria, where in 2004, Islamic clerics had refused Muslim children to be immunized on the basis of false knowledge that the vaccine resulted in sterilization—which resulted in an increase of polio incidence despite the health benefits that accrue from immunization (Jegade, 2007).

Anthropologists have a long history of examining the relationship of health and culture and has developed tools and perspectives with which to evaluate this relationship. Further, the discipline recognizes the value of its analysis and the potential impact its perspective can have on effectuating change. Some of the applications of this analysis can be negative, such as the role that anthropologists played in the US military destruction of villages in Thailand (Jorgensen & Wolf, 1970). This led to the development of a code of ethics by the American Anthropological

Association (American Anthropological Association, 2012) which guides the ways in which Anthropologists engage with the people they study. These guidelines are important to promote trust between the anthropologist and the people or community being studied. This sensitivity is based on the sensitivity that people's culture and society are an integral part of and influenced by larger socio-political, economic, historical, environmental forces (Asad, 1987; Diamond, S., 1974; Singer, 2001; Steward, J., Robert Manners, Eric Wolf, Elena Padilla Seda, Sidney Mintz, Raymond Scheele, 1956; J. H. Steward, 1955; Wolf, 1982; Wolf & Silverman, 2001). Since the end of the 19<sup>th</sup> Century anthropologists have been looking at these perspectives and have become aware of the growing gap between the medical and health care delivery systems and the ways in which people conceptualize their health and manage their own health care strategies and the ways in which health is affected by political, economic, social, religious, ecological and other influences (Foucault, 1975; Paul, 1955; Virchow, 1964). By the mid twentieth century anthropologists moved beyond studying health towards applying anthropological methods to improve health outcomes (Foster & Anderson, 1978; Hymes, 1974) and to analyze particular health challenges (Adair & Deuschle, 1970; Lindenbaum, 2013). Merrill Singer developed a critical bio-cultural model of assessing health by utilizing methods and concepts from all four fields of anthropology. In this approach, he integrates ethnographic description and analysis to understand personal perspectives, meaning systems and behaviors, political economic analysis, and a biological analysis of health-related issues (Singer, 1989, 2004; Singer & Baer, 2012). In this effort he has reconceptualized disease in a bio-social context, called syndemics (Mendenhall, 2012a, 2012b; Singer & Clair, 2003; Slubowski Keenan-Devlin, 2014)

Medical perceptions and disease definitions change over time with consequences for treatment, cultural and social relationships, and perceptions of self and affect strategies for



prevention, diagnosis, treatment and care. Understanding the individual's perceptions and how it affects their health management strategies may have an impact on their health outcomes (Adair & Deuschle, 1970; Evans & Lambert, 1997; Foucault, 1994; Leatherman, T. 2001; Leonard & Robertson, 1992; Lindenbaum, 2009). Evans and Lambert (Evans & Lambert, 1997) in their study of sex workers in Calcutta, sought to understand local definitions of health and well-being, and how these might affect therapeutic strategies. As an exploratory study, a qualitative research strategy was adopted, and the study aimed to situate the women's health practices and understandings analytically within the specific political-economic and social context of their everyday lives. They used the term "strategy" rather than "behavior" in relation to health management, in an attempt to characterize it more accurately as a type of purposeful action than as a behavioral domain that is unreflecting, predetermined (by cultural beliefs or structural location within society) and symbolically meaningless." (Evans & Lambert, 1997, pp. 1793-1794). Further they propose "a consideration of the interactions between cultural understandings of health and ill health and the particular socio-economic environments in which they are located is required, in order to give due weight to the influence of material conditions upon both strategies for seeking treatment and interpretations of their effects" (Evans & Lambert, 1997, p. 1801).

Empowering people to manage their own health has become a means by which more appropriate health care can be accessed and is a more cost-effective approach to health care services. Cultural competency has become a recognized and valued component of health care as it increases trust between the patient and the provider, improves health outcomes, reduces disparities and provides people with culturally appropriate tools with which to manage their health. An increasing number of certificate programs in cultural competency are now being

offered, and new employment opportunities are being created for culturally competent interpreters, culturally competent community health workers and culturally competent physicians, nurses and other health professionals. The need for and benefits of cultural competency in health care are well documented (Boone & Schwartzberg, 2010; Lindenbaum, 2013; Rose, 2010)

However, there is a growing distance between an anthropological perspective of cultural competency and socio-ecological context and analysis and the simplified application of ethnographic tools that are increasingly being used for rapid assessments and to promote behavior or cultural change. Rather than focusing on teaching a methodological approach to learning about culture, cultural competency is being defined as knowing a lexicon and a variety of cultural norms, specific attributes or idiosyncrasies that can also be defined as stereotyping. According to Susan Scrimshaw “*Competence* implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. A culturally competent healthcare setting should include an appropriate mix of the following: a culturally diverse staff that reflects the community(ies) served; providers or translators who speak the clients’ language(s); training for providers about the culture and language of the people they serve; signage and instructional literature in the clients’ language(s) and consistent with their cultural norms; and culturally specific healthcare settings.” (Scrimshaw, 2003, p. 69).

Ethnographic description and analysis are an important part of the anthropological methodology for examining people’s health management strategies. They are especially useful in eliciting different descriptions, conceptions and rationales for individual health beliefs,

decisions and practices (Kleinman, 1980; Guilment, 1984) as well as institutional or organizational decisions (Schensul, 2009; Schwartzman, 1983).

Care needs to be taken not to confuse these methods with specific tools that can be applied without an anthropological perspective. Increasingly, these anthropological methods are treated as easy to learn, fast, simple, and easy to apply tools that can be used to elicit responses from individuals without an anthropological perspective that assesses the individual's relationship to their cultural, social, political, economic environment. This inappropriate use tends to focus on simple attributes rather than the complexity of these factors and their interrelationship and often results in stereotyping rather than cultural competency. Dr. Sonja Boone shared an example of how these methods can be inappropriately applied. As the Vice-President for Diversity for a major metropolitan Chicago based university health system, she was requested to provide the physicians and other health professionals with an orientation on the specific attributes of Mexicans in Chicago so that these health professionals could provide more "culturally competent care" (Boone, 2012). She refused, because she understood that these "attributes" were a way to stereotype the people and their culture, rather than apply a serious culturally competent approach, apply anthropological methods and understand the socio-ecological environment in which that individual lives. Examples of an anthropological approach to understanding people's health in relation to their socio-ecological environment are Shirley Lindenbaum's study of Kuru among the Fore people of New Guinea, and Emily Mendenhall and Elizabeth Jacobs' examination of interpersonal abuse and depression among Mexican immigrant women in Chicago with Type 2 Diabetes (Lindenbaum, 2009; Mendenhall & Jacobs, 2012).

In this study I apply an anthropological method, using socio-ecological analyses, ethnographic interviews; rapid assessment procedures; formal, semi-structured, tape-recorded

interviews; informal, semi-structured interviews; and participant observation. This research study will identify and elicit individual concepts of health issues related to metabolic syndrome and determine the strategies that people living in the Austin community use to manage their health (Biehl, 2007; Hunleth, 2011; Kleinman, 1980, 1995; Leatherman, 2001; Levy & Storeng, 2007; Mendenhall, 2012a; Pattillo, 2007; Scheper-Hughes, 1993; Scrimshaw & Hurtado, 1997; Stack, 1974; Sweet, 2008).

Ethnographic description and analysis will be used to evaluate the organizations that constitute the community health coalitions. Ethnographic evaluations are essential to contextualize the ways in which the organizations and coalitions view themselves and how they are viewed by the people who associate with them as professional staff, volunteers, leaders, and as clients. This methodological approach is especially helpful in situations in which there are multiple parties, perspectives and interests which sometimes conflict (LeCompte & Schensul, 1999; Schensul, 2009; Schensul et al., 1999; Schwartzman, 1978, 1983).

### ***The Study***

My participant-observation in the Austin community started in 2009 as part of a collaborative Chicago Student Health Force Project between the Chicago Public Schools, a private sector health education company called InnerLink, Inc., and the Global Health studies program at Northwestern University that was initially funded through the U.S. Government Troubled Asset Recovery Program (TARP). This project fostered partnerships with all the institutions that have been involved in this study. Through this Student Health Force Project, I was introduced to the Austin community and several of the community leaders with whom I established a trusting relationship.

In preparation for this study, I identified fifteen community-based health serving institutions in the Austin community and other Chicago communities that would qualify as suitable sites for inclusion. The process of contacting these potential participating organizations started in February 2017. I wrote to these fifteen-health serving requesting their participation in this study. I did not receive any response to these letters. I followed up with phone calls to my contacts at each of these organizations and made personal visits to eight of them. These were: Austin Senior Satellite Center, Mt. Carmel Holiness Church; Friendship Baptist Church, 2<sup>nd</sup> Mt. Olive Missionary Baptist Church, PCC Health and Wellness, Circle Family Health Clinics, Loretto Hospital, and Christ Tabernacle Missionary Baptist Church. I was welcomed and well received by people at each of these organizations. I was asked to leave copies of the letter of request and additional information about the study and invited to come back for further discussions. In the end, I was only able to confirm participation by Loretto Hospital, the Austin Senior Satellite Center and the Christ Tabernacle Missionary Baptist Church.

I was aware of several events that were likely to have had a negative influence on the outcomes of these other requests. Circle Family Healthcare Network is a community based Federally Qualified Health Center (FQHC) which provides health care services to the community for forty years. Over the past two years, they have had a series of financial and governance crises. They had just hired a new Executive Director at the end of January 2017. So, even though I had worked with them for the past seven years, the new director just did not have time to even consider participating in this study. Further, they were still addressing some major organizational and financial crises and even though I knew many of the staff, the new leadership was wary of external people. At both the Friendship Baptist Church and the 2<sup>nd</sup> Mt. Olive Missionary Baptist Church there were shootings which resulted in several deaths. These events

had shaken the community and especially the leadership of these churches. In addition to security issues, the leadership of both these churches and others, although very friendly and welcoming to me, were reluctant to participate in a health study that collected personal data on their congregants. As an older white male, I believe that additional time is needed to build and establish increased levels of trust. So, in addition to the shootings, the fear or suspicion of external people wanting to collect health data resulted in their reluctance to participate in a health study at this time. So, I concentrated my efforts on the three organizations that had agreed to participate.

This study was formally approved by the Northwestern University Institutional Review Board on 28 April 2017. Data collection and research was conducted from April 2017 to March 2018 with the formal approval of three Austin community organizations: Loretto Hospital, the Austin Senior Satellite Center, and the Christ Tabernacle Missionary Baptist Church. In addition to my work with the Student Health Force, and other experiences with Building a Healthier Austin, multiple community health fairs, and the First Ladies Health Initiative, I met and worked with Janice Henry, the community health nurse of Loretto Hospital. She was instrumental in helping design the concept of this study. She supported the formal requests to engage the population of these three facilities in the study, and she was the community health resource and catalyst who made these collaborations possible.

Personal meetings were held with Camille Lilly, Executive Vice-President for External Affairs of Loretto Hospital, Tom Jones, Director of the Austin Senior Center, and Pastor David and First Lady Constella White Ford of the Christ Tabernacle Missionary Baptist Church. After a formal letter of approval was provided by each of these institutions, I met with them to discuss the best way in which to present the purpose of the study to each of their communities and to

solicit their participation in the interviews. After receiving approvals to promote the study and invite participation at the two facilities, I formally presented the study at large public meetings of the two organizations. These introductions were followed with the distribution of promotional flyers and personal conversations with individuals at both locations. The study invited people at these approved community centers over the age of 50 years, to participate in a research study on health issues such as high blood pressure, diabetes type 2, high cholesterol and cardiovascular disease. The purpose of this study as described in the Recruitment Flyer:

is to understand how people in this community deal with diabetes, heart disease and kidney disease. We seek to understand how people learn about these diseases, manage their health, where they go for treatment, and how people use the health services that are available in the community. (see Recruitment Flyer, Appendix 3)

Interested persons who met the criteria for the study were given a specific date, time and location for the interview. Since the only locations in which participants were invited to participate were in the Austin community, the prospective candidates all qualified if they registered at one of the two locations. The participants signed a Consent Form, and interviews were conducted and recorded in private rooms provided by each institution. The interviews were based on a questionnaire as part of this study which was approved by the Northwestern University Institutional Review Board. (see IRB Study Approved Questionnaire, Appendix 4). The interviews took between sixteen minutes and a little over an hour. The mean duration time of the interviews is thirty-nine minutes.

A gift card in the amount of \$25 was provided to each person who participated in the interviews. Funding for these interviews was provided by a generous grant of \$1,000 from Professor William Leonard, Chair of the Department of Anthropology.

People over the age of 50 years were selected as the focus of this study because at this age, the incidence of metabolic syndrome is considerably higher than other age groups (Ervin,

2009). Evidence from the National Health and Nutrition Examination Survey (NHANES) for the period 2003-2006 indicated that:

Males and females 40 to 59 years of age were about three times as likely as those 20 to 39 years of age to meet the criteria for metabolic syndrome. Males 60 years of age and over were more than four times as likely and females 60 years of age and over were more than six times as likely as the youngest age group to meet the criteria. (Ervin, 2009, p. 1).

### *Austin Senior Satellite Center*

To invite participation in the study for qualifying seniors over the age of 50 at both the Austin Senior Satellite Center and the Christ Tabernacle Missionary Baptist Church, I needed to find an appropriate way to communicate with their membership. After meeting with Tom Jones, Director of the Austin Senior Satellite Center, Bob Vondrasek, Executive Director of the South Austin Community Coalition Council (SACCC), and Lillian Drummond, Board member of SACCC, I was invited to present the purpose of the study to their monthly community meeting. The Community Health nurse invited me to introduce the study to the meeting of the weekly health education group. And the Pastor and First Lady of the Christ Tabernacle Missionary Baptist Church both invited me to attend their church services and present myself and the study to the entire congregation.

Each month the Austin Senior Satellite Center holds a community meeting at which 50 to 100 people attend. These meetings are used as information sessions for the people who come to the center. Information is shared about community resources and services. The meetings also serve as a public forum for the community members to raise issues of concern or to share their thoughts. Frequently, the aldermen and State Representatives attend to update the community. And the SACCC presides over these meetings, led by either Lillian Drummond, Bob Vondrasek or Juanita Rutues (Vice-President of SACCC). On Wednesday 3 May 2017, Bob Vondrasek invited me to speak at the monthly community meeting, introduce myself, share my concerns



about diabetes and cardiovascular disease and explain the purpose of my study. Bob introduced me to the group and I spoke for about twenty minutes with a lot of questions and answers. Immediately afterwards, I attended the weekly health education session with ten persons in attendance and explained the study to them in more detail. I talked with them as a group and then again on an individual basis to see if they would be interested in scheduling an interview with me. Nine of the people who attended the weekly health education sessions and who had their blood pressure and pulse measurements taken for up to five years, also agreed to share these measurements. One male from this group was staunchly against providing any information for a study that he did not know exactly what was going to be done with his information. He actively tried to discourage the other members from participating, fortunately without permanent effect. He also tried to discourage other members from the larger community from participating. He was concerned about sharing his personal health information and was suspicious about how this information was going to be used. Even after talking with him at great length, he was adamantly opposed and shared his skepticism widely. A follow up interview with him to learn more about his concerns and suspicions would be useful.

Each week I circulated among the seniors at the Senior Center as they were eating lunch to talk more about the study and to invite them to sign up for an interview. After a few interviews there was a snowball effect and I received even more interest than I needed for the study. While the \$25 gift card was a very helpful incentive, most of those interviewed expressed great surprise and pleasure to receive the card at the end of the interview. The first interviews started on Tuesday 23 May 2017 and the last of twenty-nine interviews at the Austin Senior Center was completed on Wednesday 3 August 2017.

### ***Christ Tabernacle Missionary Baptist Church***

At the First Ladies Health Initiative in August 2016 which was held at the 2<sup>nd</sup> Mt. Olive Missionary Baptist Church on Chicago Avenue, I met Pastor Ford and First Lady Constella White Ford of the Christ Tabernacle Missionary Baptist Church. Christ Tabernacle was one of four other churches that had been invited to join 2<sup>nd</sup> Mt. Olive Baptist Church for the health screenings and immunizations. So, when I wrote to Pastor and First Lady Ford on 23 February 2017, they responded positively. I met with them and the “Church nurse” Sister Wynn on Sunday 30 July 2017. The role of a church “nurse” in this Baptist church community is of great support to the congregation. Church “nursing” has been described as a Christian calling to serve others with the church (Newsome, 1994). As Newsome explained:

The interviews described church nursing as a Christian calling to serve others within the church. The role of nursing within the church was found to be unique and include activities which provide comfort and support to the church. The similarities noted between the church nurse and the professional nurse could be significant in developing joint projects to facilitate the implementation of health promotion and health educational programs within the African American church and community. (Newsome, 1994, p. 134)

The roles and responsibilities of the church nurse are to be caring, compassionate and patient and to provide comfort and support to the church community. Some of these responsibilities are directly related to the health of the community such as providing water, taking blood pressure measurements, providing health information, responding to health emergencies, being trained in CPR and AED and first aid, and providing solace and comfort to people and families suffering a loss (St. Paul Baptist Church, 2018). Sister Wynn was not trained as a health professional and works professionally as a medical coder. Her job is to assist the Pastor and First Lady and the Deacons of the church and respond to their personal needs and comfort. She is also responsible for responding to the members of the church during the Sunday

service by providing water, comfort, physical assistance, and calling for medical support if necessary. In addition, she serves in their Christian Education Ministries by teaching Bible Study classes. She serves on the Women and Children's Ministries by organizing meetings and activities and coordinating the volunteers who participate in these groups. Sister Wynn was the lead organizer in the annual fund raisers, and special dinners and events. She knows every member of the Congregation. And she was working full time as a medical coder, on the north side of Chicago while providing these services.

In later conversations with Sister Wynn, it became clear that she was very interested to learn more about health issues such as cardiac arrest, stroke, seizures, low blood pressure, etc., so that she can be prepared to recognize the symptoms in members of her congregation. She also felt that there could be a great benefit for having a health committee. There are health care professionals who are members of the church, and she felt that everyone could benefit from knowing more about their health issues and how to manage them. I introduced her to Janice Henry and will follow up with the health committee concept.

After I had spoken at the Sunday service, Sister Wynn organized all the congregants who wanted to participate in the study and had them sign up for appointments. She arranged a private interview room and scheduled all the participants each week. And as with the Senior Center, there was a snowball effect after the first few interviews, which resulted in having more people interested in participating than we could accommodate. The interviews were conducted after the Sunday morning services, until the Deacons had to close the facility at around 2:00 pm. The eleven interviews were completed by 27 August 2017.

### ***Blood Pressure Measurements***

One of the contracted services offered by Loretto Hospital to the seniors at the Austin Senior Satellite Center was to take weekly blood pressure and pulse measurements. These measurements were recorded by the Loretto Hospital health provider (either a staff physician or nurse) and maintained at the Hospital. Of the nineteen participants in the study from the Austin Senior Center, nine had been attending these weekly meetings for up to five years. These participants agreed to share their measurements as part of the study, and both Loretto Hospital and the City of Chicago Department of Family and Support Services agreed to release the data. On December 5, 2017, two hundred eleven records were provided for analysis. The analysis of this data is presented in Chapter 6 on Quantitative Analysis.

### ***Collaboration***

Many issues facing contemporary societies are larger than any one sector can resolve by itself. Responding to a public health issue for example, requires public sector policies, programs, and funding, and benefits from private sector and civil society sector cooperation. In looking at the spectrum of culturally competent, affordable, accessible and appropriate health services and information that are involved in the prevention, control and elimination or eradication of disease and that enable individuals to more effectively manage their health, there is a movement towards collaboration for more effective impact of these resources. Three examples of successful collaboration which resulted in better health outcomes with reduced health care costs, took place in Camden, New Jersey, New York City, and in a national program to reduce obesity (Ackermann, 2013; Carrillo et al., 2011; Truchil et al., 2017).

In Camden New Jersey, a group of healthcare providers became concerned with the rising costs of care, and an increased utilization of expensive and ineffective emergency room care and

hospitalizations. They formed the Camden Coalition to more effectively identify and enroll the highest risk Medicaid patients and share information and resources among a group of providers to ensure continuity of care and monitor their progress and outcomes. Their purpose in forging a coalition of providers was to foster communication and collaboration. Their efforts succeeded in reducing emergency use, improved health outcomes of their high-risk patients, and reduced the costs. Based on their success, and with the implementation of the Patient Protection and Affordable Care Act, The New Jersey legislature enacted the New Jersey Medicaid Accountable Care Organization Demonstration Project in 2011. This legislation promoted the organization of a large geographically based, coalition of hospital systems, primary care physicians and even community organizations into Accountable Care Organizations they partnered with UnitedHealthcare which was the largest Managed Care Organization in Camden. All Medicaid recipients were enrolled and assigned to these ACOs. The result was significant sharing of experiences, analysis of data, and adjustments to their programs based on the collective lessons learned. And most importantly, they found that by managing the highest cost patients who had unmanaged conditions, the result is better health for those patients and cost savings for the ACOs (Truchil et al., 2017).

New York Presbyterian Hospital developed a population-based model of coordinated care by developing the Regional Health Collaborative. Their purpose was to improve the health of a specific geographical region of Manhattan by enhancing and aligning the health care systems throughout the neighborhood. They created a network of patient-centered medical homes and formed a medical village linked to the neighborhood health care providers and community-based resources. The result of this coordinated care and communication initiative was a significant

reduction in emergency department visits by patients with diabetes, asthma and congestive heart failure (Carrillo et al., 2011)

A third example is the effective partnerships between public and private and civil society organizations to collaborate to prevent or delay type 2 diabetes called the National Diabetes Prevention Program (DPP). These partnerships include federal agencies, state and local health departments, national and community organizations, employers, public and private insurers, health care professionals, university community education programs and businesses that focus on wellness (U.S. Congress, 2009). One such collaboration was the relationship between the U.S. Centers for Disease Control and Prevention, National Institutes of Health, Robert Wood Johnson Foundation, the National Council of YMCAs of the USA and Northwestern University (Ackermann, 2013). The collaboration between these groups was a process with a common goal to demonstrate that DPP could improve health or reduce healthcare costs for adults at high risk for developing type 2 diabetes, by promoting individual commitment, social will and environmental change. This can be achieved through programs providing education, counseling, problem-solving and ongoing support for healthier lifestyle behaviors, even when the environment is not enabling these activities. This collaboration with a national youth and family focused organization provides a good example of what might be achieved. The reputation of the YMCA at local, state and national levels added recognition to the DPP and fostered new partners to join such as the UnitedHealth Group which explored a separate partnership with the YMCA that aligned community-based delivery of the DPP with health system strengths for identifying and engaging high-risk adults. This new relationship in turn promotes the rapid growth of the program and new research opportunities (Ackermann, 2013, p. S355).

These three examples of collaboration demonstrate the positive impact such cooperation, coordination, and communication can have on increasing access to health, improving health outcomes and reducing costs of healthcare.

Another example with global impact is immunization programs, and especially eradication programs, such as the global polio eradication initiative, which could never succeed without joint collaboration and effective coordination between each of the three sectors (Aylward, 2003). In fact, even thirty years after the polio vaccines were invented by Jonas Salk and Albert Sabin, there were still 350,000 cases of polio in 125 countries worldwide (Fine & Griffiths, 2007). It was only after an effective partnership was designed and implemented by the World Health Organization in cooperation with UNICEF, the U.S. Centers for Disease Control and Prevention, and Rotary International in 1988, and with substantial additional contributions from national governments, the Bill and Melinda Gates Foundation, and the pharmaceutical companies that polio has been eliminated from the Americas, Southeast Asia, Western Pacific, Europe, and Africa. The number of cases of global endemic polio have been reduced to 11 cases in two countries by July 2018 (Arita, Nakane, & Fenner, 2006; Aylward, 2003; Duintjer Tebbens et al., 2010; Henderson, 2016; Rotary International PolioPlus Committee, 2013; Thompson & Tebbens, 2007; World Health Organization, 2018). Substantial recognition and credit for the success of the global polio eradication program has been given to this partnership (Diamond, M. 2001; Rosenberg, Hayes, McIntyre, & Neil, 2010)

### *The 5C's Framework for Effective Collaboration*

From my professional experiences these successful collaborative efforts require five criteria for success: Convergence of Interests; Cooperation; Coordination; Communication and Catalyst. In this section, I will provide the 5 C's Framework for Effective Collaboration.

Dr. Allen Goldberg is a home care physician with expertise in high technology home care, telemedicine/eHealth, and mobile health care. He pioneered home care for technology-dependent children with former Surgeon General C. Everett Koop, MD, ScD, at the Children's Hospital of Philadelphia. He is board certified in Pediatrics, Anesthesiology and Medical Management and is a Past President of the American College of Chest Physicians. (Goldberg, 2017a). Dr. Goldberg spent a summer in 1967 in France working with ventilator assisted children. He and Dr. Koop developed the first pediatric home care discharge program working with a local community in New Jersey and later in Chicago (Goldberg, 2017b). In 1980 he continued his education with the French medical system of home care and learned of the French Ministry of Health "Centres du Documentation" (Documentation Centers). Information on health issues was available through these Documentation Centers that could be accessed in local communities throughout France by both individuals learning about illness and how to manage their health, as well as technical medical information for physicians and other health providers. Later as President of the American College of Chest Physicians, Dr. Goldberg invited Surgeon General Koop to participate in several symposia on the importance of accessible, culturally and linguistically appropriate and understandable health information (CHEST, 1999) (CHEST, 2000). Dr. Koop believed deeply in the importance of accessible health information and created one of the first health information related commercial websites [www.DrKoop.com](http://www.DrKoop.com) in 1997 (Modern Health Care 2001). While this website went bankrupt in 2001, other sites such as



[www.WebMD.com](http://www.WebMD.com) became commercially successful. However, Dr. Koop was committed to promoting the use of the internet and other collaborative resources for disseminating health information. With his colleagues at the College of Physicians of Philadelphia, he created a new collaborative website: [www.phillyhealthinfo.org](http://www.phillyhealthinfo.org): A Gateway to Delaware Valley Health Services. This website was hosted at the library of the College and was led by a medical librarian, Andrea Kenyon. They created a collaboration with the Philadelphia public library system and many health-related public, private and civil society organizations in the Philadelphia and Pennsylvania region. Their goals were to: 1) Empower citizens of the Philadelphia region to make better informed health decisions and to raise awareness of the health issues most affecting this region; and 2) Provide access, via the web, to credible health information and relevant health resources with the Philadelphia region. PhillyHealthInfo enables individuals, families and communities to take greater responsibility for their health. (Kenyon, 2008). There was an online database of health-related resources and services, and health related events; information on specific health issues and recommendations in different languages with links to other credible health websites; and a library reference service for questions submitted through the website. In addition, the Philadelphia Libraries agreed to allow the College of Physicians of Philadelphia to open PhillyHealthInfo Kiosks at five sites in the greater Philadelphia area. These kiosks provided community-based, personal assistance and were staffed by trained volunteers with computers. These volunteers were to provide individualized help to bridge health literacy and technological barriers. Their target audience was seniors, immigrants, and vulnerable populations. The program was funded by grants from the Pew Charitable Trust and with the collaboration and partnership of the College of Physicians of Philadelphia. In 2005, Dr. Goldberg and I received funding for a feasibility study to establish community health

information centers (CHICS) throughout Chicago, based on the Philadelphia model and to design a framework for the Chicago program (Diamond, M. & Goldberg, 2005). In February 2006, we visited Philadelphia to evaluate the health information programs of the College and explored several of the health information kiosks and health education programs in the city. For the next two years, working with the CHEST Foundation of the American College of Chest Physicians, we developed a proposal and prototype website for a network of community health information centers (Diamond, M. 2006). As part of the effort to promote innovative concepts of integrating health information with health services through collaborative partnerships, the Chest Foundation created a three-year Case Competition in collaboration with the Northwestern University Kellogg School of Management. The first competition winners were presented their awards by Dr. C. Everett Koop in May 2008 (Northwestern University Kellogg School of Management, 2008) <sup>1</sup>.

The American College of Chest Physicians, and the CHEST Foundation were valuable partners in this effort at building a health information resource system. They had previous experience in fostering collaborations which resulted in the formation of the Chicago Asthma Consortium (CAC) in 1996. Prior to this collaboration, there were many asthma related organizations providing information and services throughout the Chicago area. Unfortunately, there was little cooperation or coordination and as a result there was duplication of services, conflicting information, competition for limited resources and an atmosphere of conflict. Dr. Allen Goldberg, Sydney Parker and other colleagues at The American College of Chest Physicians played an instrumental role in mediating the relationships and forming the CAC. According to their website, CAC is the only local coalition dedicated solely to improving the

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<sup>1</sup> I served as the mentor for the winning team on their Home Clean Home concept

lives of those living with asthma in the Chicago area and is one of the oldest and largest asthma coalitions in the country (Chicago Asthma Consortium, 2018).

Out of these experiences with Dr. Goldberg and with the YMCA and Rotary International, we developed the concept of the 5 C's as a Framework for building effective collaborations within and between the public, private and civil society sectors. (Figure 6.)

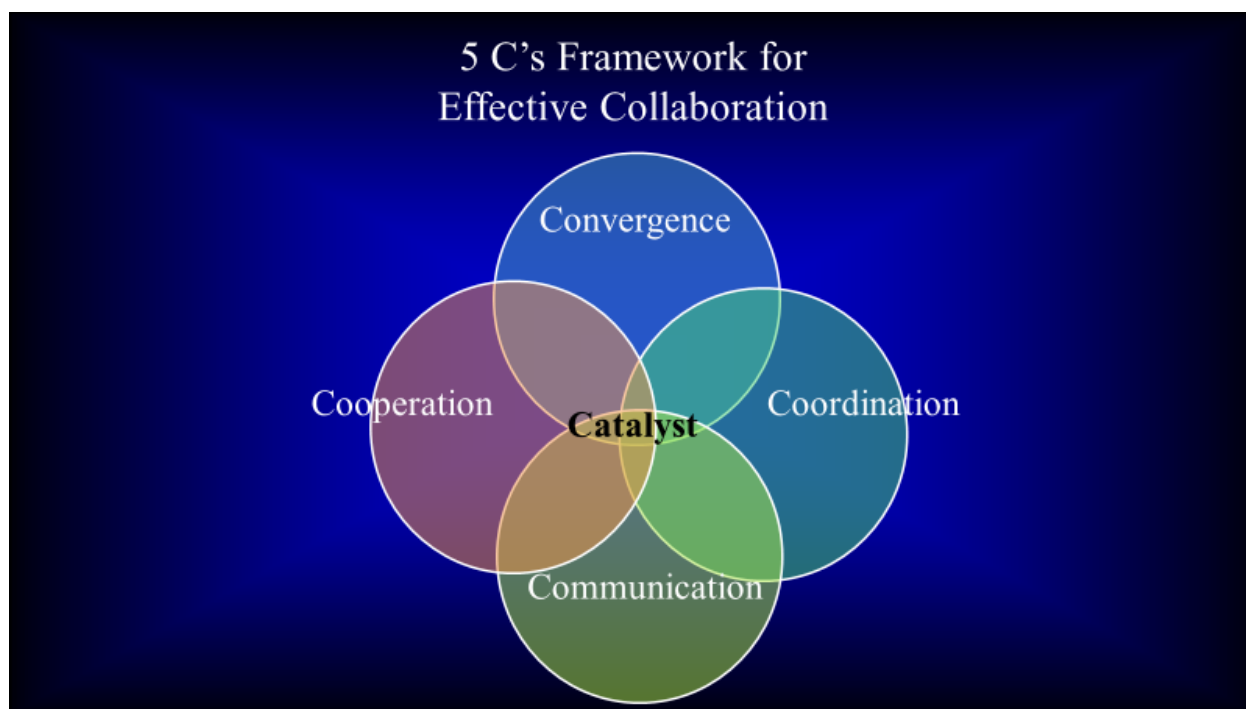


Figure 6 The 5C's Framework for Effective Collaboration

This framework includes 5 components: 1) Convergence; 2) Cooperation; 3) Coordination; 4) Communication; and 5) Catalyst. When combined in a purposeful manner, these five C's are an effective framework for designing and implementing any collaborative health intervention program. Convergence refers to an area of common interest on which organizations in the public, private and civil society sectors can agree to address. It is essential to identify and define these areas, which in turn will then facilitate cooperation among the many organizations whose goals address these same or similar problems. An example of a convergent

interest is people's love for their children, which became an important part of the polio eradication program. Everyone wants to protect their children, and immunization against polio provides this protection. Cooperation between the organizations and sectors engaged in a public health program ensures a willingness to work together that also promotes effective use of resources, accountability, transparency, leadership and partnerships, and helps to build and strengthen local and national health systems. Cooperation requires a commitment to engage with others and to share resources and ultimately, recognition. There is often a reluctance on the part of some organizational leaders to cooperate as they are concerned about losing funding, personnel, or recognition. But experience has demonstrated that their values actually increase as a result of effective cooperation (Ross, 2012). Coordination is necessary to determine the roles and responsibilities for efficient functionality within and among organizations and people engaged in an effective public health program. A good example is the use of Humanitarian Clusters in disaster or emergency situations. (Clarke & Campbell, 2018; United Nations Office for the Coordination of Humanitarian Affairs, 2018). Communication is essential to ensure consistent and credible information is provided because many of the global health problems are complicated and multi-faceted. In a public health intervention, it is necessary to define large problems into manageable chunks to effectively coordinate services. Good communication will reduce confusion, clarify responsibilities and help people better manage their health. And a fifth C – Catalyst is necessary to promote the other 4 C's. Programs that are designed under this framework do not happen by accident, they require purposeful action. Leadership and advocacy as a catalyst must be provided by an individual or an organization.

The Global Program to Eradicate Polio is a good example of the 5C's where Rotary acts as the catalyst; people's love for their children is the area of convergence; cooperation and

coordination has been fostered between WHO, UNICEF, CDC, national governments, pharmaceutical manufacturers, and Rotary and communication is jointly implemented (Rotary International PolioPlus Committee, 2013).

Another important example is the formation of Clusters by UN organizations such as UNHCR to effectively coordinate the efforts of governments, intergovernmental organizations, private businesses and NGOs which work in refugee, or disaster situations. These clusters promote coordination for sectors such as protection, shelter, food, health care, water, sanitation, education, vocational training (Clarke & Campbell, 2018).

### ***Conclusion***

This chapter described the value of an anthropological methodology that looks at health from a socio-ecological framework and includes biological, cultural, social, economic, political, and historical factors in its analysis. The relationship between these factors including structural violence and social determinants on stress provokes a biological/physical response of the HPA Axis and its impact on obesity and other health issues related to Metabolic Syndrome such as hypertension, diabetes type 2, and cardiovascular, renal and liver disease was described. The purpose of this study and the application of an ethnographic survey analysis and biometric measurements of blood pressure was outlined. And the institutions involved in this study, Loretto Hospital, Austin Senior Satellite Center and the Christ Tabernacle Missionary Baptist Church were introduced. Finally, this chapter explained the importance of collaboration between the public, private and civil society sectors. Three examples of effective collaboration in health were presented. And based on the research of effective models and personal experience, the 5C's framework for building and strengthening collaborations was described. This framework was used in this study and the analysis will be presented in Chapter 7.

## CHAPTER 5 ETHNOGRAPHIC AND SURVEY ANALYSIS

As noted in the opening chapter, the purpose of this study is to assess the impact of a collaborative community-based health initiative on the health status of people over the age of 50 years of age in the Austin community of Chicago. The rates of both morbidity and mortality related to heart disease, obesity and diabetes type 2 continue to increase for all population groups, including those defined by age, gender, ethnicity, race, socio-economic status, religion, sexual orientation and lifestyles (Ervin, 2009; National Center for Health Statistics, 2017a). As evidenced from the City of Chicago Public Health Statistics, the incidence of metabolic syndrome is significantly higher among African Americans living in Chicago communities than the non-Hispanic White communities (Chicago Department of Public Health, 2012b). This study examines the premise that people over the age of 50 years participating in a collaborative health education initiative will benefit from increased access to qualified health information and timely, affordable treatments associated with health issues related to metabolic syndrome. This study will also examine the impact of aligning individual health management strategies with appropriate access to qualified health information, and clinical health services and community support, provided by a community health organization. The U.S. Department of Health and Human Services has identified the lack of health literacy as a major obstacle for people living in minority communities such as Austin, to obtain, process and understand basic health information and services needed to make appropriate health decisions (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2010, p. iii). All population subgroups might benefit from an increased alignment between the public, private and civil society sector resources that promote access to culturally competent, community-based health information, management strategies, and health services that also address social

determinants of illness and health (Boone & Schwartzberg, 2010; Kleinman & Benson, 2006; Komaric, Bedford, & van Driel, 2012; Luque, Ross, & Gwede, 2014; Magnani, 2018).

The Austin community of Chicago was selected as the location for the study based on these criteria: 1) a Chicago community with high rates of mortality and morbidity due to underlying health issues related to metabolic syndrome; 2) a history of structural violence which affects both the social determinants of health as well as health outcomes; 3) a variety of health resources provided by public, private and civil society sectors; 4) an innovative community health education program that was designed to foster collaboration between the public, private and civil society sectors; and 5) existing relationships with people in the community,

### ***The importance of collaboration***

Despite common assumptions that collaborative strategies are complex, daunting and random, these purposeful and deliberate strategies reduce disparities, improve health outcomes, lower costs, increase access to qualified health information and more available clinical services and empower the community (Carrillo et al., 2011; Lemieux, 2013; Truchil et al., 2017). To develop more efficient strategies and improve health outcomes in Austin and other Chicago communities, there have been organized attempts, over the past decades, to promote health on a population basis through collaborative community-based coalitions, and wellness initiatives. For these resources to be more effectively utilized and have a greater impact on improving health, the public, private and civil society sector institutions and organizations should design their services based on an understanding of the actual strategies that the community members use to manage their health rather than depend on the members to find these resources on their own.

This study focused on two community-based organizations in the Austin community with a population group of over 50 years of age. The study analyzes ethnographic data and blood

pressure measurements to determine the impact of a purposeful collaborative health effort on the understanding and management of health issues related to metabolic syndrome.

This study indicates that through a public, private and civil society sector collaborative health program, community members over the age of 50 years can control their hypertension, better understand and manage their health, reduce their stress and access appropriate services when needed on a timely basis. As we will see, trust, consistent and qualified health messages, easy access to appropriate and affordable resources, and coordination between a health center, health providers, and community groups are elements of successful collaboration.

### ***Collaboration for community health education in the Austin Satellite Senior Center***

As part of its 2012 strategic plan to realign, reform and reinvest in Chicago communities, The Chicago Department of Public Health transitioned its primary care operations and services to Federally Qualified Health Centers in Chicago (Chicago Department of Public Health, 2011; Choucair, 2012). An integral part of this *Healthy Chicago* plan was to reinvest in partnerships and one key target was adult hypertension (Chicago Department of Public Health, 2011, p. 5).

In July 2012, the World Health Organization (WHO) in cooperation with the Mayor of Chicago, Rahm Emmanuel, designated the city of Chicago as part of their Global Network of Age-Friendly Cities. (City of Chicago, 2018b) Through this initiative WHO identified age-friendly community support and services that offer service accessibility, support older adults in identifying the resources they need as and when they require them, provide emergency and planning care, and are affordable (Johnson, 2015). To design and implement an Age-Friendly Chicago Plan for the city of Chicago, the Department of Family and Support Services and its Senior Services Area Agency on Aging identified their goal to address the diverse needs and interests of those Chicagoans over the age of 60 years who are healthy and active as well as those



who are frail and homebound (City of Chicago, 2018b). The agency operates six Regional Senior Centers that act as community focal points for information and assessment and provide services for seniors in health and fitness, education and recreation. It also partners with non-profit groups to operate ten satellite senior centers that offer information and assessments as well as opportunities for cultural enrichment, health and fitness, and education (City of Chicago, 2018d). One of these satellite senior centers is in the Austin Community of Chicago.

***Austin Senior Satellite Center and the South Austin Community Coalition Council (SACCC)***

Driving west on Congress Parkway and Leamington Street in the Austin neighborhood of Chicago, I arrived at Lillian Drummond Street, evidence of one of the heroes in the community. The street is named in honor of “the Angel of Justice” Lillian Drummond, who, at ninety-six is the feisty, loud, angry, force behind the SACCC. The Austin Senior Satellite Center is located there.

Walking through the gated and enclosed parking lot, I noticed several cars with bullet holes, a sharp reminder of the violent environment of the Austin community. Upon entering the facility there is a front desk, always staffed by 2 to 3 women. All visitors are required to register and are greeted with a warm welcome and a lot of gossip. The Austin Senior Satellite Center has a lunchroom with a food preparation area, fitness room equipped with 2 treadmills, 2 exercise cycles, weights and mats for yoga and stretching, a large central multipurpose room with computers and a library and serves as a community meeting hall, a dance studio, exercise classes, and other community events. There is a library and one small meeting room with a table and chairs that can accommodate up to fifteen people. There is a large space for offices. Tom Jones, the Director of the Center, and Lillian Drummond, SACCC Board member, each have their own office. Behind the front desk is space for several office staff and volunteers, and there are three

private offices for management staff and the social workers. The facility serves as a warming center in the winter and a cooling center in the summer for seniors.

The Austin Senior Satellite Center was opened on 17 January 2004 as part of the City of Chicago initiative “Neighborhoods Alive with Seniors”,

The Neighborhoods Alive with Seniors initiative addresses the many needs and improves the quality of life of Chicago’s seniors – our city’s most valuable asset. The seniors of the Austin community now have a facility right in their neighborhood to socialize with friends, learn computer skills, to exercise and to have lunch. Mayor Richard M. Daley (Public Building Commission of Chicago, 2004)

The Center was designed to provide a direct link to community-based programs and services and is operated by the City of Chicago Department of Family and Support Services and staffed by volunteers and part-time paid personnel from the SACCC. The Center serves seniors over the age of 60 years who live within the 24<sup>th</sup>, 28<sup>th</sup>, 29<sup>th</sup> and 37<sup>th</sup> Wards (City of Chicago, Satellite Senior Centers (City of Chicago, 2018e).

Several of these Center SACCC staff and volunteers helped to build the facility. One of the Vice-Presidents of the SACCC who also serves as the Center Assistant Director explained the background:

Oh well because, um there was nothing out here in the Austin community for our seniors. So, basically, this is a senior center. And there were no activities, in and around the south Austin community. And then if we had to do anything we had to go further north, and it was out of our area, and transportation and stuff is something that seniors don’t necessarily have. And back then we didn’t have the same type of facilities to ride, you know for \$1 or \$2 with so we had to think of something else. And since we had been involved with Daley for such a long time, for other things, we, one of the things he always said, well what is it that you guys want up in? And we wanted, we seniors, we wanted us a center. They (City of Chicago) actually built this center, this was a, this was a school, part of a school. It was ah, the May School down there. It was a what do you call it, an extension of that. And it had closed down, and so we had, ah SACCC had its office in there. Couple of years, two three years and then after that, we kept fighting with Daley and on getting this building and then he ah, came through for us. (Juanita Rutues)

And another senior explained the purpose even more clearly:

This is a senior satellite center. Which is basically, our, what we're really trying to do is save the seniors. Because they're the ones that's raising the grandchildren. They're the ones that taking care of the children so if we don't stay well, who's going to stay well? (90)

The SACCC was started in 1974, after its predecessor Organization for a Better Austin was closed. Ed Bailey was the powerhouse community organizer who led this coalition for 28 years before he died at ninety-one years old in 2005. The SACCC is an example of a powerful community organization based on the organizing principles, strategies and tactics of the infamous and legendary Chicago community organizer, Saul Alinsky. While Ed was focused on gang violence and drugs in the community, his co-leaders Bob Vondrasek, and Juanita Rutues were concerned with housing issues, such as contract mortgages and evictions, utility issues such as incorrect billing and cutting of services, and health. In addition to organizing protests, storming City Council meetings, and challenging Mayor Daley they worked hard to resolve billing issues and getting electricity and gas services restored.

During my observations at the Center from 2015 to 2017, there were three key personnel who managed the Center. Tom Jones was the full time Director of the Center since it opened in 2004 and he was employed by the Department of Family and Support Services. Tom passed away in September 2017. He was in his 80's. Lillian Drummond and Bob Vondrasek were the leaders of the South Austin Coalition Community Council. Lillian is a local legend in the community and at 96 years of age is a leader in the struggle for social justice in the Austin community. Her nickname is "the angel of justice" and she has spent her life fighting for the people of her community. On 22 October 2015, Mayor Rahm Emmanuel presided over the naming of the street at Congress Parkway and Leamington avenues as Honorary Lillian

Drummond Parkway (Romain, 2015). Bob Vondrasek was the Director of the SACCC and worked with them for 32 of their 33 years. As a white community organizer, Bob was recognized as being a fearless advocate for helping people fight against unjust foreclosures and slumlords, helping families with their energy bills, fighting crime and mentoring youth. He also drove community members to their doctors' appointments and offered employment opportunities through the Council.

In their fight against the Northwest Incinerator located in West Humboldt Park, SACCC joined 34 other organizations to form the Westside Alliance for a Safe and Toxic-Free Environment (W.A.S.T.E). This group worked through non-binding referendum campaigns, protest rallies, (some at the incinerator site), educational campaigns, developing alternative proposals to incineration, lobbying the state legislature, door to door organizing, and filing lawsuits. The campaign ended prematurely due to the misuse of funds by the sole employee, but the incinerator was shut down after a successful lawsuit by the Department of Justice on behalf of the EPA against the City of Chicago. Bob Vondrasek explained that the work of the SACCC continued beyond this campaign. Vondrasek is quoted as saying “most community organizations work on three issues: housing, education and safety – but the SACCC works on every issue in the community, including healthcare, labor and the environment as well as the other three. SACCC has always seen low income utility issues as one of the organization’s main concerns, and some of their current work investigates price gouging by gas companies in the current “energy crisis” (Palmer, 2006).

At ninety-six years of age, Lillian Drummond is still working hard. After graduating high school, she attended the Washington Trade School and started making hats. She found a better paying, but physically more demanding position with the Illinois Railroad cleaning

coaches, (usually with bleach). Finally, for thirty years she worked at Nabisco until she retired. In 2016, Nabisco closed its last Chicago bakery and moved the six hundred jobs to Mexico. This infuriated Ms. Drummond. As a single mother caring for her daughter, and ten grandchildren, she worked hard to house, feed and clothe them. One day she received a bill from the utility company charging her \$1,000 for her monthly service and threatened to cut off her service if she did not pay. Furious, she attended a meeting of the SACCC at one of the local churches and found that there were many people facing the same problem.

Bob Vondrasek was at that meeting. In his professional career, he is a Certified Public Accountant, and provides pro bono tax and accounting. As a member of the SACCC he helped people resolve their issues with the utility companies, Internal Revenue Service, City of Chicago, and other billing services. He helped Lillian resolve her problem with the utility company, and then took her, and others with him as he advocated for new policies, procedures, and protections for consumers. They organized demonstrations, protests, and advocated for federal, state and local programs to provide financial support and protection for consumers. Through this process, Lillian found an outlet and focus for her passion and voice for justice. She has organized and led countless campaigns, protests, marches, petitions, community meetings, and personal encounters with political leaders. She continues to be feisty and angry at social, economic and political decisions which affect the lives of the people in Austin. Her language is salty and loud.

The SACCC organizes a monthly meeting at the Senior Center. These meetings provide information about new resources such as senior housing options, or health insurance options, or other new initiatives that are offered to seniors by government, private businesses, or civil society organizations. Often there are cultural or recreational excursions that are organized by the SACCC for the seniors and are promoted at these monthly meetings. These meetings also

serve to galvanize and organize the seniors into actions such as protests to promote or protect their interests. Usually led by Ms. Drummond, petitions are circulated, and buses provided to transport the seniors to Springfield, or city hall to protest. One recent example of this type of organized activity was against the efforts to transform the closed CPS Robert Emmet Elementary school into a community health and wellness center as described in Chapter 3 as a current example of structural violence. The publicly recognized voice and spirit of Ms. Drummond was one of the reasons the proposed development was stopped (Dean, 2017).

In the interviews with seniors at the Center, participation in these organized protests with Ms. Drummond was one of the benefits they received. They travel by bus to protest at events in Chicago and in Springfield. With financial and logistical support provided by the Service Employees International Union (SEIU) and other unions, buses are arranged, lunch, snacks, signs, flyers and other promotional materials distributed, and key messages are communicated. Participating in these events is fun, stimulating, adventurous, and cathartic. The participating seniors feel better because of these activities. It helps to lower their stress. And for those who do not actively participate in the protests, they feel better just knowing that their community is actively struggling to protect them. During the weekly meetings at the Senior Center, organizations and businesses come to promote their services. Sometimes it is clear to the community that the organization is trying to take advantage of them. One example is the new Oak Street Clinic that opened in nearby Oak Park. Their representative came to several meetings and offered free ice cream to anyone who would sign up with them. He received very angry responses from the seniors:

We don't need the ice cream. They don't need the ice cream. They need something. They need more services, more services here. More help, more resources, you all can get them, more resources help them out, get them things they can't get. Let's just say I wouldn't jump. How would I get over to the thing. You all come and get us. Nope. (65)

Several seniors were furious at this effort to purchase their participation and commented that this group was just trying to get their Medicare funding. This opportunity to learn and exchange ideas with a community of people they know is of great value and impacts the quality of their lives in a very positive way. Many of the seniors interviewed in this study recognize the value of these protests and activities to help them relieve their stress. By participating in these organized demonstrations, they feel informed and empowered to take specific actions.

The seniors are also attracted to the center for exercise. There are daily dance classes and fitness classes led by trained and energetic professionals. The exercise room and equipment are another incentive. At their monthly community meetings, their political representatives and representatives from other organizations are invited to present the seniors with their services.

These presentations frequently spark vigorous discussions and debates about the political, economic, and social issues, and assess the quality of the services, the intentions behind the services, and experiences are shared. The Center also provides hot lunches at a discount, and free vegetables and groceries several times a week so the seniors have a safe space to eat and talk.

With the exception of the full-time director, Tom Jones, all other staff are part-time employees paid by the SACCC as part of their contractual arrangement with the City of Chicago Family and Support Services to manage the facility. The volunteers are trained by the staff and act as receptionists and help with clerical and administrative functions. (Tom Jones passed away unexpectedly in September 2017, and after July 2017, Bob Vondrasek became incapacitated by Alzheimer's and was unable to participate in any further discussions.)

The primary services provided by the Center focus on housing, utilities, social services, health and other support that is needed by the seniors and their families. The loss of such

powerful and experienced leaders is an issue, due to the lack of younger people who are as passionate, articulate, and able to earn the trust and confidence of the community.

Q: So, you would go in as an advocate for them and try to get it resolved?

90: We still do it. But yeah, you have to come to us. We don't have the capabilities to, you know. And there aren't any organizations, our organization is a older organization. So, we don't have the staff, nor do we have the young folk that needs...see back then, if you go back to 50, and you figure out how old I was back in the 50's or, you'll understand that it was much easier. But these younger folk, has, have to step up. Which they're not doing. (90)

Social capital is one of a community's most valuable assets, and new opportunities for engaging and training younger people in the leadership and governance of these institutions is essential (Montgomery & Inkeles, 2000). With all these personnel changes at the Austin Senior Center, it will be interesting to see how these collaborative relationships might also change. There is a clear lack of leadership training opportunities for younger people in Austin which creates issues of leadership succession. One of the most successful examples of a city sponsored leadership training program is the collaborative New York City Mayor's Volunteer Youth Corps. This two-year program offered adolescents who had dropped out of high school and had become involved with the justice system, an opportunity to restore their credibility, complete their high school degree or GED, learn discipline and workforce skills, provide valuable services to people and communities throughout New York City, and in many cases learned leadership skills (Jaffe & Freedman, 1987)

The collective impact of these programs and services, including the weekly health education programs provided by the Austin Senior Satellite Center were evaluated through the interviews with seniors who regularly participated in the Center activities and by analyzing their blood pressure measurements over a period of five years.



### *Loretto Hospital*

Health is another major focal point for the Senior Center. Juanita explained that the SACCC had originally organized a senior facility nearby and one of their major concerns was health.

And the reason for that, we we, um, you know people have had diabetes and we've had other problems, heart, blood pressure, we've had that all our lives. So, and, with the eating conditions out here, where we not had for a very very long time, any direct food stores, major food store it was a problem. And we had a lot of situations. And so, one of the things we wanted in here, was, ah, and I think Loretto worked along with us in getting it, Loretto Hospital. And we would meet like once a month, and the seniors would get together, and then we all started having meetings at Loretto hospital. (Juanita Rutues).

In 2012 the Senior Services Area Agency on Aging contracted with Loretto Hospital to provide a weekly health education and assessment program at the Austin Satellite Senior Center. This program would be organized by a medical professional, either a physician or a nurse affiliated with Loretto Hospital. These weekly programs are three hours long and include a formal presentation on a health issue relevant to the needs and interests of the seniors in the community, an open discussion session, and measurement of blood pressure and pulse rates which are recorded.

During the period I worked with Loretto, from 2009 to the present, Camille Lilly has been the Executive Vice President for External Relations. She is also the elected State Representative for the Illinois 78<sup>th</sup> District and is President of the Austin Chamber of Commerce. She has been instrumental in securing grants and donations to support these senior services, and other community health related events and programs. In addition to these responsibilities, Ms. Lilly recently completed her MBA from the Northwestern University Kellogg School of Executive Management. Her focus is on managing health and wellness to include both medical and social/environmental services.

Under her leadership, Loretto Hospital has offered special programs for seniors as part of its Community Health and Wellness Program. Ms. Lilly started screening, health education, and wellness activities aimed at all ages of people in her district. Informing citizens of local health resources is another valuable service. Through its Golden Life Senior Wellness program, free bus transportation is provided to any senior coming to the Hospital for clinical services. There are free health screenings, community health fairs, and special events and activities at the Hospital. Among the most popular of these events was a monthly birthday party celebration. Free lunch and cake were provided to all seniors who came to celebrate the monthly birthdays. This was a great incentive to get the seniors out of their house and to socialize with others. Unfortunately, this very popular program had to be stopped due to funding and other issues. Another popular program that was initiated was the weekly walks. Having a specific time, date, and organized leadership for these walks was helpful to schedule their participation. A special arrangement with the American Heart Association provided free pedometers as a further incentive. On one day in Spring 2013, the walk was so successful that the group of seniors, and staff members kept walking and did not return for the rest of the day. This sparked an informal message: “keep walking...but remember to come back”. However, the local park is not a safe space, due to wild animals such as coyotes, and security concerns such as the high numbers of shooting and homicides, so the regular walks have been discontinued.

Janice Henry is the community health nurse at Loretto Hospital. In addition to being a Registered Nurse, she is also a certified Pharmacy Technician. During her career, she has provided home health care, worked with a veteran’s health service agency, several health insurance companies providing health fairs and information sessions, at private homes, in acute care facilities, and at major Chicago Hospitals doing research. She was well known in the Austin

community for her participation in religious activities through her church, her professional services and her volunteer work. At a community immunization fair, Camille Lilly approached Janice and invited her to work as the community health nurse at Loretto. Janice's relationships with other community organizations is provided in Chapter 1. She is a trusted and respected health provider in the community and a valuable link to any health service that is needed.

From the beginning of her work in the community, Janice recognized diabetes and heart disease as two of the major health issues. People didn't have to seek Janice out for health care, she found them. She took care of a lot of people through her church.

well, people, um, I'm kind of nose-y like that. So, you don't have to come to me to ask me for help...I get in your business, you know, and if, let's say for instance., when we do alter call, if they are praying especially long for somebody, then I would know that something is wrong. And, I needed to go and see what was wrong. You know, or, sometimes the pastor would say, you know, um, you know, Ms. so and so, or Mr. so and so you know, um, can you go by and see what you can do for them?

Her method of engaging with the patient is to:

just show up. That's what I do, I show up. And you know, there's no such thing as you are not going to let me in. you know, so, you know.

And she learned that people did not have difficulty knowing what their diagnosis was...

I'm not going to say that they didn't know what their diagnosis was. I'm not going to say that. I'm gonna say, it's one thing to know what your diagnosis is, and not know what it means. You know. We do a really good job of diagnosing people, and then leaving them on their own to figure things out.

people that um, maybe weren't taking care of themselves you know, like they should. Um, people, you know, things are not really explained to them, so, you didn't really know how to take care of yourself, because nobody ever took the time to sit down and explain to you. You know, why it's better to use a meter to check your glucose than the urine dip test. You know. Those kind of things.

And she found that even when the patient has a primary care physician they still have problems:

...a lot of the people have private doctors. You know, they go to a clinic that they trust, or they go to a clinic or doctor in their community. Um you know there were certain doctors that everybody went to, you know, but still, you know, even today what most people today do, is they go to the doctor, and they hear what they have to say, and it doesn't mean anything, because they don't understand it.

This lack of communication also extends to medications. In many cases, Janice helps people obtain the medications they need through referring them to appropriate services:

Right, before the 4-dollar list came out, um there were um, every pharmaceutical company gives medicine away for free. But, did your doctor tell you that? No. do the nurses who work in those offices or clinics, do they tell you that? No, cause maybe they don't even know. You know, um, if you have open formulary then um, um, drug reps come in and they bring you whatever, but they rarely tell you, or if they are telling you, you know, you are not listening to it. Um, That there is help for people who need this medication. (Henry, 2017)

Janice makes herself available to accompany them to medical appointments or emergency room. One patient called her at 2:00 in the morning and asked her to take her to the emergency room at Rush Hospital in Oak Park. While she was sitting waiting, a physician from Loretto Hospital who was working a private shift at Rush, saw her, and became furious because she was not taking the patient to Loretto. He wanted to make sure that Loretto received the payment for the service rather than Rush and reported her to the management at Loretto. Janice explained that she was just accompanying the patient and did not make the referral. This is an example of the ways in which medical services are often provided on the basis of payments rather than on the care for the patient. A further example of this attitude is the list of recommended post care facilities that a patient can access upon their release from the hospital following their medical procedures. In the case of West Suburban Hospital in Oak Park (contiguous with Austin), the list they provided included only those providers who had agreed to pay a referral fee back to West Suburban. If the provider did not agree to pay, even if they were in close proximity to the patient, they would not be included in the list. Patients often have to seek care further away than

necessary which results in transportation costs, increased time, and frequently delayed or no follow up care.

I spend time going to doctor's appointments with people, sitting in the room with them while they have their doctor's appointment, and listening to what the doctor says, and asking people, did you understand what they just said? Well not really, you know. So, I spend a lot of time translating doctor talk to things that people can actually understand. Even now. I will tell a family member as much as a patient wants told. You know, I'm more than likely what I spend a lot of time doing, is, you know, after a doctor's appointment, taking a person to lunch or whatever, or breakfast and explaining to them, you know, making sure that they understand what the doctor said, making sure they understand the consequences of not following you know, some kind of medical advice, and making sure that they have what they need, you know, um, doctors, often write prescriptions and never ask you, can you afford to buy this medication, you know, uh, for the most part, people want to be in compliance, nobody really wants to be sick, you know, unless you have Munchausen, you know, but most people, most people want to be well. They want to be able to do the things that they want or need to do. You know, but the question is, can you afford to do it? You know, and that is a big question, you know. (Henry, 2017)

One of the most important issues for Janice, is not the lack of health care resources in the community, it's access to the kinds of services that people really need.

I was at a meeting the other day, with some other health care providers, and um, I think that was what we were talking about... how we sometimes don't do enough to promote the services that we actually have. And that we need to give better at doing that. You know, I think that um, right here in Austin, people can get the majority of anything that they need, you know, at a provider in Austin. (Henry, 2017)

While community health asset maps, and web-based lists, guides and materials are available, they are not easily accessible to the community members, especially seniors (Chicago Department of Public Health, Healthy Chicago 2.0, 2018). It's the personal connection:

We have resource guide that we have in this community. So that would certainly be a place to start. You know. But, we had this meeting the other night, you know, and said that what I think that what people really want is you know, a personal touch. You know. What people need something they need to have a person that they can call, to get whatever they need. So, for myself, even though it's probably one of those things that gets me in trouble, I'm going to say, that I don't have a particular horse in a particular race, um. I think my job is just to make sure that people have what they need. You know, and if Loretto is the best place to provide it, then its Loretto. If it's not, then it's not. I think, that every organization has to do their own advertisement of their services, but all the time

advertising is not going to get it. Um, It has to be that people have a relationship with people or with organizations, and that is how things get done. (Henry, 2017)

From my own experience, I met a woman at the First Ladies Health Initiative who was diabetic and required an annual eye exam. She had not had an eye exam for the past three years, even though she understood how important such an exam was. When I asked her why she did not have an exam, she explained that the staff at the local public health clinic told her the nearest ophthalmological service which accepted Medicare and Medicaid was located about five miles away and required two buses to get there. I asked her why she didn't just go to Loretto Hospital for the exam which is only two blocks away. She replied that she did not know that they offered this service. This is just another example of the impact of a lack of qualified health information about community health resources and services.

As a community health nurse, Janice is called upon to provide health information and support on a wide range of health issues and different population groups. She works with all the health issues challenging the Austin community: diabetes, heart disease, kidney disease, lung disease, cancers, obesity, mental health, reproductive health, adolescent health, HIV and AIDS, substance abuse, pre and post-natal care, births, deaths, homicides, and suicides. When a three-month old child was accidentally shot and killed, Janice was the person called at 3:00 in the morning to help the family find a coffin and arrange a burial service, without charge. She secured a donation to create a computer-based cancer focused health information center at Loretto Hospital that would be open to the public. The room was secured, the computers purchased and installed, reference materials gathered, and university student volunteers had agreed to act as resource guides in this community health information resource center. But, because the center was in the hospital which had to have a secure environment, it could not be

opened to the public. The room sits today fully functional and serves as a meeting room but not as a community health resource center.

When asked how community health can be approached from a more holistic perspective, she replied:

we have to get back to the fact that health care should be a caring business. It can't always be always be money and profit and those kind of things. We have to remember that we are dealing with people's lives and that I won't need the same things that you need, and you won't need the same things that I need, you know. But we all need to be understood, you know, you all need to be cared for, um, you know, we all need an equal shot at being able to be well. You know, or, whatever our concept of well is, because, what my concept of being well and whole is not going to be the same as yours. You know. Your idea of wholeness or wellness may be a home and money and cars and things like that, and mine may not be. But we should all be able to be as whole and as well as we can be. And we shouldn't be um, um, you know, inhibited from doing that. I think that the person that doesn't have any insurance at all has the same right to my services as somebody else. You know, and that's why I do a lot of work what some people are going to say on the side. You know, because everybody deserves to have a good nurse, they deserve to have a good doctor, they deserve to have somebody who genuinely cares about them as a whole, as a person, and their family. You know. So, how do we get back to that? I don't know. But some people...a lot of people are going into the medical field because of the money. And I can guarantee you, I don't make anything like what I'm worth. (Henry, 2017)

### ***Health Education Program at the Austin Senior Satellite Center***

Since she started working at Loretto, Janice has been responsible for the health education program for the Austin Senior Satellite Center. Each Wednesday from 1:00 to 4:00 pm she leads the health education sessions. The meetings start with informal banter and sharing of personal information. Then there is a presentation on a specific health issue. Materials such as journal articles, flyers, brochures, and other health related information, are distributed. Several of the people interviewed at the Center explained that even if they don't attend the sessions, they make sure to collect copies of these materials, because they are so helpful. One of the members complained that she finally had to start to throw them away because she collected and stored

them at home, and they were now taking up too much space. Janice also arranges for physicians, and other health professionals and educators, to speak every Wednesday.

These topics include: diabetes blood pressure; obesity; impact of tobacco, alcohol and other addictive substances including foods; arthritis, HIV and AIDS; reproductive health for seniors; safety; exercise; cancers; the importance of a colonoscopy and annual physical checkups; explanations of medications; how to respond to an active shooter situation; nutrition; etc. Even though there is a focused presentation, the seniors ask questions on multiple topics and share their personal stories.

Frequently, specific adverse health events are discussed and there is considerable concern expressed from the other seniors. One of the seniors (96) who is sixty-six years old, has been coming to the Center for the past 5 or 6 years. After moving to the neighborhood, she started coming to the center instead of sitting in her house. From her first day, she was welcomed at the Center. She found that the socializing at lunch motivated her to walk to the Center every day. And then she went on some of the trips and really enjoyed the experiences. She started to have pain in one of her legs and she would complain about it to her friends at lunch. One of the other seniors took her to West Suburban Hospital.

He took me, he took me to the hospital. I'm gonna take you somewhere else, cause I kept complaining to him about, my leg. And he was taking me around. (I) was just in at the table he's at, You come over with me. I said what do you give orders like that? You come over with me. He he he. Took me, take me home. (96)

West Suburban doctors could not identify the problem and prescribed pain medication.

From when um I told the people I was going to, I said I don't like that, at Loretta, not Loretta, West Suburban, they kept giving me pills, aspirin, stuff, that goes to my leg. Till I find out they had to do surgery on my leg. (96)

Since she was not satisfied with her treatment at West Suburban, her friend drove her to Rush Hospital. There, they examined her leg, took x-rays, and determined that there was a clot which



had to be surgically removed. The physician at Rush said that if she had waited another day, they would have had to remove her leg.

So, he (at West Suburban) did all kinds of x-rays and never saw that. This man's saw it at Rush. No blood was coming through. So, he had to open it up, do that, um hm. Good. If I had waited that day, they would have taken my leg off. I thank god. (96)

Today, she continues to receive physical therapy at Rush and exercises regularly at the Senior Center. Her friend invited her to come to the Wednesday Health Education program and she has been a regular member ever since. When asked what she knows about diabetes or cardiovascular disease, she replied "It doesn't concern me a lot, because I don't have it." But she does have high blood pressure and takes medication. When asked whether this weekly meeting is helpful,

it definitely pays something, I hadn't paid attention to it, or somebody made me more aware of different things, that we have in the class. different things like, that, like the high blood and stuff. And different things, that can, like you, you lose them limbs and different things. Ah, strokes and different things. (96)

She is aware of her blood pressure measurements and tries to keep her systolic BP under 140 mm Hg. She reports that it has been lower, like 135 or even 130. But it has also been higher. She is aware that some of the adverse results of high blood pressure include strokes, heart attack, and problems with her kidneys. She also has an arrangement for a nurse to visit her weekly, measure her blood pressure and make sure she is taking her medication. She has participated in the protests and demonstrations as well as the more recreational outings organized by the Senior Center. But when her friend did not feel well and did not want to go on a recent protest at City Hall, she decided to stay with her friend. She attends her church every week, Janice is the community health nurse for that church. Janice offers regular screening sessions, shares health information and is available for consultations. Janice has started a health committee at the Church. When asked if people at the Center cared about her, she commented, that during her

health crisis, when she did not show up at the Center, her friends would call her at home to see how she was.

cause they call me when I' couldn't come here after my leg. They was calling me all the time. How you doing? Um hm, they always call. (96)

This is a good indication of the impact of this health education program. The impact of this approach will be further evaluated through the analysis of the blood pressure measurements of members of this group over the past five years. Patient-centered group diabetes care is getting more attention. Group care has been found to be helpful in delivering interactive, patient-centered diabetes education and care. A recent clinical Doctor of Nursing Practice capstone project assessed the impact of a group approach and found that this mechanism for education and care was effective and encouraged further studies on the impact of this approach (Esdén & Nichols, 2013).

(22): right, right, well, I can tell, especially with the stroke. I can tell you know, when my exercises are, if I'm not doing it on a consistent basis, because my balance goes off. Um besides that, the stroke affected more on my left side, ways more. It makes my body tilt more and I'm off balance. So, I know, after missing, you know, even a week, I can tell the difference.

Q: the friends that you meet here, are they on your case too? Do they support you?

(22): They support, we support each other. You know, we support each other. You know we met what can we support each other might of fact, I had a you know, off campus, what social get to together, for some of my classmates, from the fitness class. So, we try, you know, to keep in touch with each other.

Q: so, if you didn't show up one day, somebody would be knocking on your door?

(22) yeah, yeah, somebody would call, or you know, somebody would call me and let me, check and see how I'm doing.

Q: How does that make you feel?

(22) It makes me feel important. It makes me feel that I matter.

### ***Christ Tabernacle Missionary Baptist Church***

Reverend David Ford became the pastor of Christ Tabernacle Missionary Church of Austin in January 2012. He was ordained in 2004 at the Rock of Ages Baptist Church in Maywood. His ministry was recognized by Pastor Marvin Wiley of the Rock of Ages Church

and he was sent to the Christ Tabernacle Missionary Baptist Church on a mission to reinvigorate their congregation. Other members of the Rock of Ages Church joined with Pastor Ford on this mission. In addition to being the Pastor of the Church, Rev. Ford works in partnership with several community organizations such as Sharing Connections, and Safe Haven. Christ Tabernacle had originally been organized in 1964 and had finally moved to its current location on Central Avenue in 1976 with a membership of over 700 people (Ford, 2017). The building is a prominent structure consisting of three major parts. The first is the sanctuary which can accommodate over 1,000 people. It has a large pulpit and a choral space. In the basement of the sanctuary is a large multipurpose room with a full kitchen. The basement extends to another large area which serves as a day care center. There are two private rooms, one for meetings, and the other for the First Lady of the Church, Constella White Ford. I was invited to use her private office and the meeting room for the private interviews. Above these rooms are several apartments which serve as private spaces for the Pastor, and the Deacons of the Church. There is a third building that is attached to the other two which may have been a school at one point. There is a large gymnasium with a full basketball court. And there are two floors of rooms which can serve as classrooms and day care. This part of the building is not used yet to its full potential and requires some rehabilitation. This part of the building is quite impressive, and could serve as a revenue generating space for the Church if a plan was developed for classes, recreation, training, etc.

As noted before, I met Pastor Ford, and First Lady Constella White Ford at the First Ladies Health Initiative the previous year, when they brought members of their congregation to the 2<sup>nd</sup> Mt. Olive Missionary Baptist Church to participate in the health screening and immunization program. With some words of encouragement from Janice Henry, Pastor Ford

agreed to meet with me to discuss the study. On Saturday afternoon 28 July 2017, I met with the pastoral nurse, who is called Sister Wynn to discuss the study. That evening I received a letter from First Lady White to meet with Pastor Ford the next morning, attend the service, make an appeal to the congregation from the pulpit, and join them for a special dinner following the service. I was warmly welcomed by Pastor Ford, the First Lady and by the entire congregation. Sister Wynn organized the sign-up sheets and spoke personally with the congregants to encourage those over the age of 50 to participate. Within two weeks, twenty people had signed up. I completed eleven interviews, and there is continued interest for follow up. Each of the persons interviewed also received a \$25 gift card, which was always gratefully appreciated.

### *Analysis*

Forty participants were interviewed who met the criteria for participation in the study. For the purposes of this study, I divided the people I interviewed at the Austin Senior Satellite Center and the Christ Tabernacle Missionary Baptist Church into three groups. Two of these groups participated in the Austin Senior Center, one of which attended the weekly health education meetings and the second did not participate in the health education meetings but did participate in other programs offered at the Center. The third sample group came from the congregation at the Christ Tabernacle Missionary Baptist Church. All forty people in these three sample groups met the criteria for the study, were over the age of 50 and signed the Consent Form in which they agreed to be recorded.

Twenty-nine interviews were conducted with eligible participants at the Austin Senior Satellite Center. Of these, ten participated in the weekly health education sessions and nine of these had their blood pressure and pulse rates measured over a period of five years. Permission to use their measurements was obtained from each participant, Loretto Hospital and the City of

Chicago Department of Family Support Services. Two hundred eleven records of their blood pressure measurements were obtained from the data collected by Loretto Hospital. Nineteen other seniors participated in the interviews and did not participate in the weekly health education sessions. Eleven participants were members of the Christ Tabernacle Missionary Baptist Church of Austin and did not participate in the Austin Senior Satellite Center activities (See Table 4). The interviews took an average of 39 minutes with the shortest at 16 minutes and the longest over an hour. The participants were interviewed in a semi-formal environment which was private and provided by each facility, so they were comfortable. Each interview was based on a questionnaire designed to obtain background information, their reasons for coming to the facilities, their personal health issues, their family health issues, their knowledge of health issues related to metabolic syndrome, how they managed their health and if they had a health plan. (Appendix 4).

Based on their responses in these interviews, several patterns emerged.

Table 4 Participants in the study on health issues related to Metabolic Syndrome

PARTICIPANTS IN THE STUDY ON HEALTH ISSUES RELATED TO METABOLIC SYNDROME			
1 May 2017 - 30 April 2018			
Participants	Programs		
	Austin Senior Satellite Center	Christ Tabernacle Missionary Baptist Church	
Participants in Weekly Health Education Seminar	10	0	
Participants without participation in Weekly Health Education Seminars	19	21	
Total Interviews	29	21	40
Total Interviews Transcribed	10	10	20
Participants in Weekly Health Education Seminar with Blood Pressure Measurements	9		
Blood Pressure Records Received	211		

***Reasons for participation: socializing, exercise, community engagement***

As can be seen in Table 5, for Group 1 which attends the Senior Center and participates regularly at the weekly Health Education meetings, 60% of the participants indicated that the primary reason for their attendance is Socializing. 30% came primarily for the Exercise. And 10% participated primarily because of the Community Engagement opportunities. Their secondary reasons for participation are: Health Issues – 50%; Exercise – 20%; Community Engagement – 10%; Socializing – 10%; and Food – 10%. Their tertiary reasons were Health Issues 20%; Community Engagement – 10%; Socializing – 10%; Exercise – 10%; and no response – 50%.

For Group 2: Community Engagement Opportunities were 80%; and Exercise – 20%. Their secondary reasons for participation are: Socializing – 80%; and Health Issues – 20%. Their tertiary reasons were safety – 20%; Exercise – 20% and Socializing – 20%. No answers were provided for 40%.

For Group 3: 100% of the participants responded that the Pastor was the primary reason for their participation in the Church. Their secondary reasons were: Nurse Ministry – 20%; Service to God – 20%; Socializing – 20%; and no response 40%. Their tertiary reasons were Self Improvement – 40%; Service to God – 20% and no response 40%.

Table 5 Reasons for Participation in the Programs

REASONS FOR PARTICIPATION											
PRIMARY REASON	Socializing	Exercise	Community Engagement	Health Issues	Food	Safety	Pastor	Nurse Ministry	Service to God	Self-Improvement	No Response
<b>Group 1</b>	60%	30%	10%								
<b>Group 2</b>		20%	80%								
<b>Group 3</b>							100%				
SECONDARY REASON											
<b>Group 1</b>	10%	20%	10%	50%	10%						
<b>Group 2</b>	80%			20%							
<b>Group 3</b>	20%							20%	20%		40%
TERTIARY REASON											
<b>Group 1</b>	10%	10%	10%	20%							50%
<b>Group 2</b>	20%	20%				20%					40%
<b>Group 3</b>									20%	40%	40%

Group 1 Participants in Weekly Health Education Program at Austin Senior Center

Group 2 Participants in Austin Senior Center but not participants in Weekly Health Education Program

Group 3 Participants at Christ Tabernacle Missionary Baptist Church and not participants in Weekly Health Education Program

### ***Reasons for participation: reduces stress and increases health knowledge***

A second pattern emerged regarding the impact of the Austin Senior Center on the reduction of stress and the increased understanding of health issues. In Table 6 are the responses to the question: Did the program help reduce your stress and did it provide you with appropriate health knowledge?

Table 6 Participation in the Program Reduces Stress and Provides Useful Health Information

Does Your Participation Reduce Stress and Provide Useful Health Information?				
Group	Reduced Stress YES	Reduced Stress No Response	Increased Health Knowledge Yes	Increased Health Knowledge No Response
Group 1	90%	10%	100%	
Group 2	100%		20%	80%
Group 3	0%		40% but not through Church	60%

Group 1 Participants in Weekly Health Education Program at Austin Senior Center

Group 2 Participants in Austin Senior Center but not participants in Weekly Health Education Program

Group 3 Participants at Christ Tabernacle Missionary Baptist Church and not participants in Weekly Health Education Program

For Group 1: 90% of the participants reported reduced stress and 100% felt their health knowledge increased from their participation and connections with Janice.

For Group 2: 100% reported reduced stress from coming to the Center. And 20% of the participants reported better access to helpful health information.

For Group 3: 0% reported lower stress from attending church, and 40% reported access to health information, but not through the Church.

***Reasons for participation: personal health issues***

A third issue became clear. People are also concerned about their own health issues and see the Austin Senior Center as a reliable, trusted place to receive information about their health, and where to find appropriate and affordable services. Groups 1 and 2 especially trusted Janice Henry. The people in Group 3 relied on family, friends, and primary care physicians, emergency rooms, but with very mixed results and confidence. Table 7 presents their responses.



Group 1: High blood pressure – 60% of the participants reported having high blood pressure and were concerned about strokes and cholesterol; Diabetes: 20% reported having diabetes. 10% reported depression as their primary health issue; and 10% had insurance problems.

Group 2: 60% reported high blood pressure, cardiovascular disease, includes liver complications. 40% reported diabetes as their primary health issue.

Group 3: 40% reported diabetes as major health issue; and 40% cardiovascular disease and high blood pressure.

Table 7 Participation in the Program Addresses Personal Health Issues

Does Your Participation Address Personal and Family Health Issues?							
Personal Health Issues							
	High Blood Pressure and CVD	Diabetes Type 2	Depression Mental Health	Insurance	Cancer	No Response	
Group 1		40%	10%		20%	30%	
Group 2		20%				80%	
Group 3	20%	60%				20%	
Group 1 Participants in Weekly Health Education Program at Austin Senior Center Group 2 Participants in Austin Senior Center but not participants in Weekly Health Education Program Group 3 Participants at Christ Tabernacle Missionary Baptist Church and not participants in Weekly Health Education Program							

### ***Family Health Issues***

As with the previous question, people are concerned about their family health issues. Groups 1 and 2 especially trusted Janice Henry and frequently called upon her for their personal as well as their family health needs. They felt comfortable calling her at any time of the day or night. Groups 2 and 3 had both personal and family health issues but also reported having less health information and knowledge about the illnesses, and their management. For members of

their families, the health issues that concerned them most were high blood pressure and cardiovascular disease, Diabetes type 2, Depression/mental health and Insurance. Table 8 presents their responses.

Group 1: 40% reported diabetes concerns; 20% reported issues with cancer; and 10% had concerns with depression and 30% did not report family health issues.

Group 2: 20% reported diabetes issues in their family and 80% did not report any family issues.

Group 3: 60% reported family issues with diabetes and 20% cardiovascular disease and high blood pressure.

Table 8 Participation in the Program Addresses Family Health Issues

Does Your Participation Address Personal and Family Health Issues?							
Family Health Issues							
	High Blood Pressure and CVD	Diabetes	Depression Mental Health	Insurance	Cancer	No Response	
Group 1		40%	10%		20%	30%	
Group 2		20%				80%	
Group 3	20%	60%				20%	

Group 1 Participants in Weekly Health Education Program at Austin Senior Center

Group 2 Participants in Austin Senior Center but not participants in Weekly Health Education Program

Group 3 Participants at Christ Tabernacle Missionary Baptist Church and not participants in Weekly Health Education Program

***Selected comments from the participants***

Group 1 Question: If you were sick, would someone from the Center call you?

Q: and if one day you didn't show up, do you think that somebody would call your home and find out how you're doing?

(8) oh yeah. Um hm, Yup.

Q: cause there is a real big value for this?

(8): yes, uh huh. Yeah.

(75): You got the stress in everyday life, you know what I'm saying? And we try not to, but it's you still manage to, you know, and you don't want to, an you know what it costs. I mean, just everyday living. Walking out the house you know. ...And I'm comfortable when I get here. And you know, it's just peace of mind for a little while you know. (75)

(9) And like I say, everybody thinks you're supposed to help yourself first. I say, when I help myself, I don't feel good. But when I help the other person, I feel good. I don't know if it's a psychological thing or what, you know. But like I said, I'm a take care of myself, but when you talkin about you need something, I'm gonna try to see if I get you help you with your needs. (9)

There are stark differences between the three groups of participants. Stress was clearly reduced in all the people who came to the Austin Senior Satellite Center. The facility offered a secure, safe, welcoming environment. The most important reason to come to the Senior Center was to socialize. Becoming part of this community with a group of friends on a regular basis was a major factor. And the services offered by the Senior Center were attractive and supportive. Having a safe space to socialize, exercise, participate in community events, protests, and to receive assistance with their health issues, and social services were primary factors in their participation. For Group 3 who attended the Christ Tabernacle Missionary Baptist Church, they participated for spiritual reasons, primarily based on their connection with Pastor Ford, and socializing. This group had similar health issues to the other two groups at the Austin Senior Center but had less access to qualified health information and health services through the Church. Group 3 reported no stress reduction from their participation in the Church.

The conclusion from this analysis of the three Groups is the importance of the collaboration between Loretto Hospital and the Austin Senior Center. The Senior Center is perceived as a safe, supportive space which offers a variety of opportunities and services to the Seniors. They primarily come to socialize and to use the Center's facilities: exercise classes, inexpensive food, social and political events and for a range of social services. Through the

relationship with Loretto Hospital and the weekly health education seminars, the participants also feel they have access to helpful, reliable, trusted health information and health services. From their participation in the Senior Center, they felt reduced stress and increased health knowledge. This collaborative relationship met the goals of the partnership: to address the many needs, improve the quality of life of Chicago's seniors and provide a direct link to community-based programs and services.

The Church is a spiritual sanctuary, but the participants did not report reduced stress. And while it offers a variety of social and spiritual services, the Church could benefit from an organized health program to minister to the health needs of the congregation. In my conversations with Sister Wynn, Pastor and First Lady Ford, the leadership of the Church is open to start an organized health committee to provide more health resources to their members. As mentioned in Chapter 4, Sister Wynn is very interested in promoting a collaborative partnership between health care providers at Loretto and the Church. She feels it would be a helpful way to increase the congregant's knowledge about their health, and where to access appropriate and affordable services. She also agreed that this would reduce stress and help to prevent and control health issues. She is concerned about the congregation's health. She is cooperative, knows what resources she has to share and wants to learn more about health to help others. She is an effective communicator and has the full support of her church leaders. These are all the attributes for a successful collaborative program.

***Other examples of the 5 C's Framework: Effective collaborative multi-sectoral programs to increase access to qualified, culturally competent, health resources and services***

In addition to evaluating the impact of the collaborative partnership between the City of Chicago, Loretto Hospital and the Austin Senior Center, and the previous description of the

Global Polio Eradication Initiative, I acted as the catalyst in several other local collaborative partnerships. These include: Building a Healthier Chicago and Building a Healthier Austin; and the HIRCULES Health Education project in Evanston and Skokie.

### ***Building a Healthier Chicago (BHC)***

In the early years of the new century, 2000, there was a convergence of interest on the part of health providers, payers, and health serving organizations and institutions in the public, private and civil society sectors, to improve the overall quality of life and healthy life expectancy and to reduce the disparities in health status that existed among different population groups in the United States (Alexander et al., 2003; Bazzoli, 1997; Hasnain-Wynia, 2001; Schensul, 2009; Shortell et al., 2002). Several evaluations of the health of people of Chicago from 1990 to 2010 concluded that the health of minority population groups, especially Non-Hispanic Blacks was getting worse, especially in comparison to Non-Hispanic White population groups (Hunt & Whitman, 2015; Lavizzio-Mourey, 2004; Margellos, 2004; Silva, 2001). In 2000, the U.S. Department of Health and Human Services launched Healthy People 2010 which had two primary goals: 1) Increasing quality and years of healthy life; 2) Eliminating health disparities (National Center for Health Statistics, 2012). The Institute of Medicine published its findings on health disparities in 2002 in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care* (Institute of Medicine et al., 2002). Based on these findings the Institute of Medicine convened a National Commission To Reduce Racial and Ethnic Disparities in 2004. The American Medical Association (AMA), based in Chicago, became a founding Commission member and agreed to provide professional staff support for the Commission. Dr. Sonja Boone, Director for Physician Health and Health Care Disparities for the AMA, was appointed as the Secretary to the Commission. As part of its commitment to reducing disparities, the AMA

decided to invest in a Chicago based community health program (Boone, Sonja. Personal Communication). In 2005 Dr. Terry Mason, a renowned Chicago Urologist was appointed by Mayor Richard M. Daley as the Commissioner for the Chicago Department of Public Health. In addition to promoting community partnerships for public health, he was a dynamic proponent of health and wellness programs. He was renowned for encouraging Chicago to become the “healthiest city in the United States” (Chicago Department of Public Health, 2006). And in 2007, Rear Admiral (ret) James Galloway, MD, FACP, FACC was appointed Regional Health Administrator for the Department of Health and Human Services Region V which includes Illinois Indiana, Michigan, Minnesota, Ohio and Wisconsin. Drs. Galloway, Boone and Mason, with the support of their organizations, agreed to initiate a new innovative approach to improving the health and reducing the racial and ethnic disparities of the people of Chicago. In 2008, The US Department of Health and Human Services Region V, the Chicago Department of Public Health and the American Medical Association launched Building a Healthier Chicago by convening a series of meetings and discussions with health care leaders and community organizations (U.S. Department of Health and Human Services, Office of the Regional Health Administrator Region V, & Chicago Department of Public Health and the American Medical Association, 2008). *Building a Healthier Chicago!* was founded on the US Centers for Disease Control and Prevention Social Ecological Model, which acknowledges how environmental factors impact the decisions people make. This model combines these multiple perspectives and promotes a healthy environment/lifestyle suited for the social space in which people live, eat, work and play (Agency for Toxic Substances and Disease Registry, 2011; Navarro, 2007). At its first Partnership meeting, *Building a Healthier Chicago* addressed the leading causes of death in Chicago that are attributable to a chronic disease:

We are all aware that six of the ten leading causes of death in Chicago are attributable to a chronic disease with heart disease, cancer, and stroke leading. The irony is that each of these can be mitigated by our daily choices. Poor nutrition and lack of exercise are two of the major three leading causes of these diseases (with tobacco as the third) and both of these factors are very closely linked to the ever-increasing epidemic of obesity which our nation faces. By utilizing the tremendous strengths of a multi-agency and multi-organizational collaboration empowering an integrated approach within communities, we have an unprecedented opportunity to develop effective, ecological and population-based interventions that focus on lifestyle change. It is clear that many of our partners have already developed extremely effective collaborations, strategies and interventions. Indeed, many of them have been recognized as some of the most effective in the nation. We plan to aggressively promote these interventions in efforts that are supportive to our partners, individually and collectively, and blend these with mutually developed implementation strategies to effectively target the largest portion of the United States population: those in the urban centers, starting with Chicago as the model. (U.S. Department of Health and Human Services, Office of the Regional Health Administrator Region V, & Chicago Department of Public Health and the American Medical Association, 2008, p. 2)

BHC did not want to form a new organization which could compete for resources with its members. So, it formed a coalition to: “ignite and build a social movement at private, public and policy levels in order to change broad scale social norms and create a social environment supportive of health” (Galloway, 2008)

Our VISION is integrated, effective, and sustained community wide partnerships for health promotion that can be replicated nationwide. Our GOAL is to improve the health of Chicago’s residents and employees through the integration of new and existing public health, business, medicine and community efforts. Our goals are geared towards achieving the following: Reduction of Health Risks; Improvement of Health Systems; Elimination of health disparities; and Prevention of chronic disease through increased physical activity and improved nutrition. (U.S. Department of Health and Human Services, Office of the Regional Health Administrator Region V, & Chicago Department of Public Health and the American Medical Association, 2008)

From 2007 to 2013, Building a Healthier Chicago built a strong collaborative organization which eventually had over 800 registered members. There were numerous successes such as collaborating with the Restaurant Association of Chicago which resulted in their decision to offer half plate sized servings and heart healthier food options. Fitness programs were organized in

high rise buildings throughout the city. Hearings were held on health policy recommendations which were shared formally with the Department of Health and Human Services. Through the regular meetings of BHC, there were opportunities to meet and form partnerships and cooperation between the members and share information. BHC became a model for other cities throughout the United States to Build Healthier Cities.

One of the specific programs of BHC was to demonstrate the impact of this collaboration on improving access to health and wellness resources in an underserved community in Chicago, and the Austin community was selected. As a special advisor to Building a Healthier Chicago, I was appointed to assist a coalition of health serving organizations in Austin to Build a Healthier Austin. Starting in 2010 by convening a series of community meetings which brought together over 150 community members, Building a Healthier Austin was defined as:

a non-governmental, community initiative that serves as a community-led and informed coalition working to improve the overall quality of life and well-being of the Chicago Austin community. The coalition will support other organizations in Austin through the promotion of their work, building awareness, facilitating connections, and assisting to secure additional resources and evaluate impact.

**VISION:** Our vision for a Healthy Austin is a safe, inclusive, culturally accepting, healthy community in which people are connected to health resources and information and are invested in improving their health and the health of the community. Building on existing and seeking new resources, our community fosters collaboration among all of its members, developing and promoting an environment that provides high quality of life.

**MISSION:** Building a Healthier Austin is a community-based coalition working to improve the overall quality of life and well-being of the Chicago Austin community area by building awareness, connections, and promoting healthy lifestyles. (Prewitt, 2012)

The original intent of BHC was to foster this community coalition in a similar fashion as the previously mentioned Healthy Austin coalition had been organized. Applying lessons learned from the collapse of the Healthy Austin coalition, this effort was undertaken to be sustainable by the Austin community, rather than be dependent upon external resources. BHA was to be a support mechanism for other Austin community-based organizations and not become



competitive. With this understanding, 2012 a BHA Organizing Committee was formed from local Austin residents with the endorsement of the community members who had been attending BHA meetings. As BHA was intended to be a self-supporting coalition of these community members and their organizations some funding and fund raising would be required and efforts were underway to register as a non-profit organization in Illinois and apply for tax exempt status from the IRS. Because it would take some time for the tax-exempt status to be approved, a formal relationship was established with the West Side Ministers Coalition to act as a Fiscal Sponsor. An Executive Director who was a community organizer with a health management background was hired with funds from BHC and an action plan was approved:

## **2012 ACTION GROUPS AND PROJECTS**

### **Awareness of and Access to Comprehensive Health and Social Services**

- Promote and celebrate existing health efforts by local organizations
- Asset map for Comprehensive health services resource in Austin
- Communications: Austin Weekly, Austin Times, website, mapping project
- Community Calendar to promote all Austin and Chicago health related events
- Annual Wellness Fair
- Participate in Building a Healthier Chicago efforts

### **Healthy Lifestyles and Wellness**

- Walking Clubs, annual walk a thon
- Sneaker Distribution
- Urban Gardening and Promotion of Healthy Foods Initiative
- Prepare for Annual State of Health Report for Austin (June 2013)
- Promote healthy behaviors and enhanced safety

Promote City of Chicago Health Initiatives (Prewitt, 2012)

Initially, BHC had intended for BHA to become a model of a community based and

locally supported coalition that would become affiliated with BHC. A retired tax attorney from Sidley Austin LLP provided considerable pro bono efforts to prepare the By-laws for BHA and the necessary paperwork for legal registration with both Illinois Secretary of State and with the IRS. This attorney recognized that there were substantial potential liability issues for both BHA

and BHC which had never been previously discussed. Since BHA was a consortium of three major organizations, each agency was providing professional staff, office support, and financing for many of the programs of BHC. And since external resources were required for official BHC events and promotional materials, one of the “friends” of BHC offered to register an umbrella organization called Building Healthy Communities and act as the fiscal agent for BHC. But no official relationship was defined between BHC and Building Healthy Communities. It soon became clear that both Building a Healthier Chicago and Building a Healthier Austin had to become legally registered separate entities and the pro bono lawyer tried very hard, unsuccessfully to complete the registration processes for either organization (Diamond, M., 2012a; Galloway, 2012).

Unfortunately, by 2014, Building a Healthier Chicago and Building a Healthier Austin had collapsed. At the end of 2012 funds that had been raised to support Building A Healthier Chicago and which included support for the salary of the new Executive Director of Building a Healthier Austin had been misappropriated by the Executive Director of Building Healthy Communities. With no legal oversight or direct fiscal relationship, the leadership of BHC decided not to pursue legal action against Building Healthy Communities. The newly appointed Executive Director of BHA had been hired by Building Healthy Communities and had not fulfilled its financial commitments to her. Further, funds that had been provided to her to support the BHA initiative could not be accounted for which created dramatic tensions between the BHC and BHA leadership. Dr. Galloway was unable to convince the Department of Health and Human Services that helping to formally create an independent BHC organization would be an appropriate model for other cities. Through personal discussions with Dr. Galloway, I learned that HHS was concerned that Dr. Galloway was promoting a local Chicago initiative and they

preferred that he focus all his efforts on more regional duties. In 2013 Dr. Galloway retired as the Regional Director, and the new director of HHS Region V was not interested in supporting the Building a Healthier Chicago initiative. By 2009, Dr. Mason had retired as the Chicago Health Commissioner and joined Cook County Department of Health as its Chief Medical Officer. In 2011, Rahm Emmanuel was elected Mayor of Chicago. The new Commissioner of Public Health, Dr. Bechara Choucair, was focused on reducing the Department's role in providing direct delivery of medical services due to the implementation of the Patient Protection and Affordable Care Act and promoted increased partnerships through a new Public Health initiative (Chicago Department of Public Health, 2011). The CEO of the American Medical Association, Dr. Michael Maves also retired in 2011 largely due to the controversy in response to his support for the Patient Protection and Affordable Care Act of 2010 (Becker's Hospital Review, 2010). He was replaced by Dr. James Madera who promptly restructured the AMA and by 2014 had withdrawn from the IOM National Commission to End Racial and Ethnic Disparities. So, by the end of 2014, the efforts at Building a Healthier Chicago collaborative had collapsed. There was no longer any catalyst to continue the collaboration. The City of Chicago Department of Public Health launched its Healthy City initiative in 2012, but due to the way in which it realigned its health services and funding, had lost the trust and confidence of the community partners on which the new program was heavily dependent. Funding for the collaborative effort with Loretto Hospital and the Austin Senior Satellite Center was provided by the Department of Family and Support Services. To its credit in 2016, and with a new Public Health Commissioner, Dr. Julie Morita the Chicago Department of Public Health re-designed its health plan and is currently implementing its Healthy City 2.0 Initiative (Chicago Department of Public Health, 2016a). This new plan addresses health equity, social determinants of health, and

is a collaborative effort designed to increase access to health care and human services and improving health outcomes.

***Health Information Resource Centers Utilizing Libraries in Evanston and Skokie (HIRCULES) and the Northwestern University Community Health Corps (CHC)***

After more than 100 years of providing health services to the people of Evanston, The Evanston Health Department closed all of their direct medical services, except pediatric dentistry, in 2007. (Buchanan, 2013). And as the Skokie Health Department provides only a few services such as immunizations, blood pressure screenings and refers low income patients to Chicago for care, the access to low cost, primary health care services were limited to NorthShore University Hospital and St. Francis Hospital emergency rooms. And many families took their sick patients to Cook County Hospital for care. In November 2013, Erie Family Health opened a new community health center for the people of Evanston and Skokie. This was the first Federally Qualified Health Center to open on the North Shore of Chicago (Seidenberg, 2015). This state-of-the-art facility was funded by generous grants from NorthShore University Health System, which contributed \$1.2 million for the facility and an additional \$600,000 in operating support over three years. The North Suburban Healthcare Foundation contributed \$1 million towards capital renovations and the HHS Patient Protection and Affordable Care Act provided \$650,000 as an operating grant. (Buchanan, 2013). Within a year of the opening of the new Erie Community Health Center, NorthShore University Hospital closed its Adolescent Health Services, shifting them to the new Erie Health Center. Despite the publicity and promotional events, patients in the Evanston and Skokie communities were very slow in signing up. With the new health insurance plans provided through the Patient Protection and Affordable Care Act, Medicare and Medicaid, this was an excellent opportunity for low income people in these

communities to get access to primary care services. However, many of the low-income people living in Evanston, Skokie and neighboring Chicago never received the promotional materials. Some of these residents were undocumented immigrants from Mexico, Guatemala and other countries suffering from oppression and persecution as well as poverty. They were fearful of registering with the Erie FQHC as they believed they would be identified to the US Customs Enforcement and other legal authorities and deported. They did not understand that their legal status was protected under HIPAA laws and they could register with security and safety. Many Black and African Americans in these communities were also fearful of the treatment that they thought they would receive. Since the operating hours of the new Erie Health center were limited from 9 to 5 and closed on weekends, these limited hours restricted their ability to come to the center during the business hours. And many of the other ethnic communities in Evanston and Skokie did not speak English so they did not understand this new opportunity. Over 90 languages are spoken in Skokie. Erie needed help to promote the new Health center. Their income and financial support depended on the numbers of people who would sign up for their services. Erie Health was not a drop-in center. They required all new members to receive a complete physical examination at the time of their registration so that a base-line health status would be obtained. After the initial examination, members were able to come to Erie Health at any time or call for assistance and advice. Erie staff were bilingual in English and Spanish, and services in all other languages were available through a telephone medical interpretation service.

In October 2013, shortly after the Erie Center opened, I met with the Erie Health CEO, Vice President for Development, Director of Marketing and the Chief Medical Officer of the Erie Center. The purpose of the meeting was to determine if there was any role that global health students at Northwestern University could be of assistance in the promotion of the Erie

Center to the surrounding communities. This offer was deeply appreciated, although Erie had no experience working with volunteers before. In December 2013, Professor Noelle Sullivan, Northwestern University and I met with the Vice President for Development, the Director of Marketing, and their community health educator to finalize the concept of building a relationship between Northwestern University Global Health program and the Erie Health Center. The concept was to organize student volunteers to become advocates and community representatives for the Erie Health Center. It was important to ensure that the student volunteers understood the key messages that Erie wanted to promote and that they would be considered as formal volunteers representing the Erie Health Center. By January 2014, the Erie Director of Marketing, Gerry Linda and their AmeriCorps Public Health Educator Tiosha Goss, had compiled a PowerPoint presentation of the key messages and content that Erie wanted to communicate. This concept of Community Health Volunteers was presented to Devora Grynspan, Director of International Program Development at Northwestern University in December 2013. She enthusiastically approved the concept and agreed to provide administrative and other support. Mary Paliwka, the Department Assistant helped to promote the program through her communication channels and provided other logistical and organizational support (Community Health Volunteer flyer 2014). Nancy Bennett of the Northwestern University Chicago Field Study program also agreed to support this initiative. Through the IPD promotional efforts, the global health classes at Northwestern University that were taught by Prof. Sullivan and myself, and my affiliation with several student groups such as GlobeMed, Peer Health Exchange and Engineering World Health, 40 undergraduate students signed up to become Community Health volunteers. Four training events were organized so that these students could learn about their role as Erie Health volunteers and Gerry Linda presented the

Erie PowerPoint information and promotional materials. The students formed teams of two and were required to attend at least two of the training sessions. At the final session, the teams were required to make a verbal presentation of Erie Health to the entire group and Prof. Sullivan and Gerry Linda. As a result of their successful presentation, Gerry presented each student with an Erie Volunteer nametag that they could wear on their community representations.

### ***Health Information Resource Hubs***

In December 2013, at the same time as the organizing efforts with Erie Health Centers were taking place, Dr. Allen Goldberg and I met with Carolyn Anthony who was a medical librarian and the Director of the Skokie Public Library and President of the American Library Association. She informed us that the most frequently asked questions at public libraries throughout the United States were health related and that librarians needed assistance to provide qualified health information resources to their members. She was interested in the concept of a health information resource desk that could be opened at the Skokie Public Library and staffed by Northwestern University Health Information volunteers. She was also interested in supporting and promoting the Erie Family Health Center in Evanston/Skokie. She identified two key personnel, Susan Carleton, and Kate Belogorsky to provide assistance and oversight. On 20 February 2014, Skokie Public Library hosted the first meeting with Skokie Public Library, Erie Evanston/Skokie Health Center and Northwestern University. The purpose of the meeting was to create a Health Information Center at the Skokie Public Library and was accepted.

As part of its community outreach and health education programs, the new Erie Evanston/Skokie Health Center wants to work closely with the Skokie Public Library to create a Health Information Center at the Library.

There are four major objectives of this Health Information Center:

- 1) Establish a close working relationship with the Skokie Public Library and the community groups with which it works to address the health needs of the community by providing increased access to health information and health services;
- 2) Provide qualified health information resources in a culturally competent way under the guidance and support of the Skokie Library Reference Librarian and Community Engagement Manager and health professionals at the Erie Evanston/Skokie Health Center. This Health Information Resource Center will be staffed by Community Health Volunteers who have been trained and approved by the Erie Evanston/Skokie Health Center;
- 3) Provide a two-way flow of information at the Skokie Public Library to promote the services available to the community at the Erie Evanston/Skokie Health Center and to promote the services available to the community through other community health related programs and organizations.
- 4) Conduct an evaluation of the impact of the program on health knowledge, and possibly health status as a result of this initiative.

### **Proposal to organize a Health Information Resource Desk**

It is proposed that the Skokie Public Library will identify an appropriate space for a Health Information Resource Desk. This space will include a computer terminal and files for the Community Health Volunteers to use with the general public. The space will also be located in close proximity to the Reference Librarian who can help provide guidance and direction when needed. This Health Information Resource Desk will have specific hours which will be developed in association with the Community Health Volunteers.

### **Community Health Volunteers**

Northwestern University in conjunction with the Erie Evanston/Skokie Health Center has started a program of training undergraduate students as Community Health Volunteers. These students will serve as the primary resource to staff the Health Information Resource Desk. They will be trained further by both the Erie Evanston/Skokie Health Center staff and the Reference Librarian and Director of Community Engagement at the Skokie Public Library. There are currently twenty trained Community Health Volunteers and three of them have committed to work with this project as part of the Chicago Field Studies program for spring 2014.

The Community Health Volunteers will be provided with a list of appropriate websites, and other health information resources which they can share with the community members who request specific health information. They will also collect all of the questions asked and develop a Frequently Asked Question file which will be made available to both the Community Health Volunteers and the general public.



Further, these Community Health Volunteers will help to update the list of health serving community organizations in Skokie, Evanston and surrounding communities. And they will provide support for community health fairs and other public events organized to promote the health of the people of Skokie and Evanston.

## **Resources**

The Erie Evanston/Skokie Health Center has several people who are willing to help develop this Health Information Resource Desk at the Skokie Public Library. Dr. Avery Hart is the Chief Medical Officer, who works very closely with the Commissioners of both the Evanston and Skokie Departments of Public Health. They are willing to advise this effort to ensure accurate messages, and to identify messages that need to be conveyed to the public. Tiosha Goss is the Director of the Evanston/Skokie Health Center Operations. If there are questions concerning the services of the Health Center, she can help to provide answers. Devin Gosberry is the Health Educator at the Erie Health Center and she will be the primary liaison and support for the Health Information Desk.

## **Skokie Public Library**

Carolyn Anthony, Director of the Skokie Library is an enthusiastic supporter of the concept that public libraries can serve as a trusted community health information resource. She reported that last year, there were over 28 million requests for health information at public libraries throughout the United States.

Bruce Brigell is the Coordinator of Information at the Skokie Library and as the Reference Librarian will provide guidance and technical support to the Community Health Desk.

Susan Carlton is the Community Engagement Manager and will be the primary contact at the Skokie Library for this project.

Katrina Belogorsky works with immigrant programs and literacy classes. There is an English Language Learning Center (ELL) and literacy classes. One of her projects is with the Assyrian Pharmacy and she is organizing a community health fair in April for which she can use some Community Health Volunteers.

Teen Librarian: Jessie Schulte (?) Skokie Library provides a specific space for adolescents to meet, study and have events. They sponsor a Teen Advisory Group. They could use additional support from the Community Health Volunteers and other programs at Northwestern such as the Peer Health Exchange and GlobeMed and Engineering World Health.

Youth Services Department offers Children's Storytime: Monday, Tuesday and Friday mornings at 10:30 am and on Wednesday mornings at 9:30 am and 10:30 am. There are story times for different ages – babies, infants (16-23 months), toddlers and preschoolers. There is a play center for children.

Federal Government Connection: The office staff of Rep. Jan Schakowsky and State Representative Lou Lang have started an information/help desk at the Library, the first Wednesday of every month from 5:30pm until 8:00 pm. The purpose is to facilitate a better relationship with public services offered by the federal, state, and local governments.

Council on Jewish Elderly: This group staffs an information table on the 3<sup>rd</sup> and 4<sup>th</sup> Wednesday mornings of each month.

### **Asian Health Services**

Mental Health Services: The Skokie Library provides space for Turning Point, which provides peer counseling and other mental health resources.

Health Insurance Navigator: The Library does not have a navigator. There is a navigator available at the Erie Evanston/Skokie Health Center, and we may be able to make their services available at the Library.

List of Skokie Community Health Serving Organizations: the Skokie Library collects this information and makes it available to the public. They can use additional support from the Community Health Volunteers, and possibly develop a community health asset map.

### **Northwestern University**

As part of its global health studies program, Profs. Noelle Sullivan and Michael Diamond are training undergraduates in community health services and research. There are over three hundred students registered as global health minors and many others who are interested in volunteering with community health programs. They have started the Community Health Volunteer program in conjunction with the Erie Evanston/Skokie Health Center as a way to promote the services of the health center and to provide the community with better access to qualified health information and services. There are also many organized student groups which

might be interested to provide support such as Peer Health Exchange, GlobeMed, Chicago Field Studies, Engineering World Health etc. (Diamond, M. 2014d)

With this support, additional efforts were made to engage the Evanston Public Library and other key stakeholders in health in both Evanston and Skokie communities. The purpose of such engagement was to ensure that there was full community support for this health information initiative and that there was agreement regarding the promotion of health services and qualified information. Karen Danczyk-Lyons, Director of the Evanston Public Library and Jill Skwerski, Community Liaison Librarian were enthusiastic supporters of the initiative and provide invaluable leadership and oversight to the students. The Evanston Public Library also hired a new librarian with a background of health and medicine, Ben Remson.

By April 2014, the following community groups had agreed to support the Health Information Desks at both the Skokie and Evanston Public Libraries: Skokie Public Library, Evanston Public Library, Erie Evanston/Skokie Health Center, Asian Family Health Center, Evanston Department of Public Health, Skokie Department of Health, St. Francis Hospital, Northshore University Hospital, and Northwestern University. Evanston Library had developed a list of over 1,500 community organizations in Evanston which we used to develop a database of about 1,000 health related community-based organizations. One of the student volunteers was able to geo-code these organizations and place them on a community map of Evanston and Skokie. And one student volunteered over the summer of 2014 with the Northwestern University Chicago Field Studies program to work full time with the Evanston and Skokie libraries to create the Health Information Desks.

On 14 May 2014, the Erie Family Health Center invited Skokie Public Library staff to tour their facilities. At this evening event we learned that there was already a partnership between the Skokie Library and the Erie Center. Carolyn Anthony has personal and professional interests in mental health and had opened facilities at the library for anyone seeking mental health services to connect with appropriate services. Also, the Skokie Library provided books for children and adults to the Erie Center so that patients and their children would have access to these books. On 30 May 2014, the Evanston Library hosted a meeting of the entire group. It was agreed to call the initiative Health Information Resource Centers Utilizing Libraries in Evanston and Skokie or HIRCULES and a list of program objectives was agreed to (M. Diamond, 2014a, 2014b). Over the summer 2014, the Northwestern Community Health Volunteers met weekly with me to design and implement the Health Information Desks. The students actively supported the community outreach efforts of the Libraries and participated in community health fairs. The Northwestern University Community Health Volunteers started its recruitment, orientation and training programs to support HIRCULES in September 2014. The group of students who had met over the summer became the founding leaders of the NU Community Health Volunteers CVC). They organized into committees related to the Health Desks, Communication (internal and external), and Programs and Events. One student assumed the responsibility for designing an internet Website, and another student, Anna Rietti, assumed the responsibility for registering the NU Community Health Corps (NU CHC) as an officially recognized Student organization. They organized the first public health event at the Evanston Library on 19 November 2014. Titled "In Sickness and In Health" the speakers included Evonda Thomas-Smith, Director, Evanston Department of Health; Dr. Caroline Counard, Director, Village of Skokie Department of Health; Dr. Avery Hart, Chief Medical Officer, Erie Family

Health Center; and Dr. Muhammad Paracha, Clinic Director, Asian Human Services Family Health Center. The event was sponsored by the HIRCULES Health Hub, Skokie Public Library, Evanston Public Library, City of Evanston, Village of Skokie, Northwestern University International Program Development and the Erie Family Health Center. 42 people attended the event and it was published in the Evanston Roundtable press. This event has become an annual event for HIRCULES Health Hub and NU Community Health Corps.

During Fall 2014, Winter and Spring 2015 academic quarters, the NU Community Health Corps worked on the Monthly Themes that had been approved by HIRCULES Health Hub and prepared lists of Frequently Asked Questions and organized health information resources into health-related topics such as Nutrition. The Monthly themes for 2015 were:

January: Ensure Your Health  
February: Prevent, Reduce, and Manage Chronic Disease  
March: Reproductive Health  
April: Environmental Awareness  
May: Eyes and Ears and Mouth and Nose  
June: Domestic Abuse and Violence  
July: Cancer  
August: Back to School  
September: Insure Your Health  
October: Nutrition  
November: Healthy Living  
December: Mental Health  
(Diamond, M. 2014c)

In the Winter, Spring and Fall academic quarters of 2015, the leadership of NU Community Health Corps arranged to take an independent study courses with me as a way to learn more about organizational management that could be applied to their efforts at strengthening the Community Health Corps and the HIRCULES Health Hub. A Health Advisory Committee was formed by HIRCULES Health Hub which included 8 physicians, medical and health professionals and health educators. Guidelines were prepared for the

development of these health information resources. All materials that were being provided to the public had to be approved by this Advisory Committee and were to be written for a 4<sup>th</sup> grade audience. The first topic that was addressed was Nutrition.

By February 2015, the NU Community Health Corps had formally elected its new officers, an Executive Board and committee leaders and assigned members to each committee. The two health librarians Kate Belogorsky from Skokie and Ben Remson from Evanston led a training session on how to be a health librarian. One of the principles of this initiative was for the Health Information Desks to be a guide for patrons to qualified health information available at the library or on the internet, and to help them find appropriate resources and services. But the Community Health Volunteers were not to provide health information or advice themselves. They were being trained as librarians. During this time, the physical health desks were being designed at both Evanston and Skokie Public Libraries. Space was provided, and tables and materials were organized. The Health Information Desks were to be staffed twice a week at both libraries and the student community health volunteers had to commit to a schedule to ensure that the desks were always fully staffed with at least two volunteers. Northwestern University provides access to its vehicle fleet for students who are volunteering and providing community service. The NU Community Health Corps arranged to train and certify their members as drivers and reserved vehicles so that they could commute to Skokie without having to use public transportation. Because it was so important that the launch of the Health Information Desks was well organized, and practiced, they were not officially opened until October 2015. A HIRCULES Health Hub Meeting was convened at the Evanston Public Library with all the partners on 29 May 2015 and the incoming leadership of the NU Community Health Corps and their Executive Board were introduced to all the partners.

During the summer 2015, one of the NU CHC members became a second Chicago Field Studies student assigned to the Evanston Public Library. And the other members who stayed in Evanston met weekly with me to further design the programs and content. These students also supported both the Skokie and Evanston Public Libraries with their community fairs and participated with me in the Back To School Fair in the Austin Community of Chicago in August 2015. In the Fall quarter of 2015, the NU Community Health Corps finalized its Nutrition Health cards and one of the students translated the cards into Spanish. The HIRCULES Health Hub Information Desks were opened official in October 2015. The second annual public health event was also organized. And plans were made to actively recruit new members in January 2016. This recruitment campaign was effective, and more than 60 students had joined the NU Community Health Corps. Several students were invited to the Clinton Global Initiative to make a presentation on the HIRCULES Health Hub and the NU Community Health Corps. Two of these students were presented with a special award and provided with technical mentoring and advice on innovations. Under the dynamic and energetic leadership of the two Co-Chairs of NU CHC, the programs continued to grow, and the relationships with the partners were strengthened. There were a few issues that had to be addressed such as ensuring regular participation at the Health Desks. The NU CHC Executive Board members had to work closely with their members and with their partners to successfully resolve these issues. In April 2016, a successful leadership transition was organized, and plans were designed for the 2016-2017 academic year. In May 2016, the first Camp(us) Fire event was organized as a fund raiser. One of the student leaders took the responsibility and promoted a cultural event which focused on Refugees. The evening included music, story-telling, poetry, and fellowship in support of the HIRCULES Health Hub. The process to organize this event was a significant learning opportunity for the

executive leadership of NU CHC. They had to design the program, budget, promotional materials and solicit support from their partners and other community organizations. They presented a strong case to the International Program Development and received financial and logistical support.

### ***Partnership with the American Red Cross of Greater Chicago and Northern Illinois***

The professional staff of the American Red Cross of Greater Chicago and Northern Illinois lectured to the Global Health classes at Northwestern since 2009. During these lectures, discussions were held about ways in which the global health students could volunteer and provide support to their local initiatives. As a result of these discussions, an idea was proposed to train Northwestern global health students as Red Cross Instructors for Adult and Pediatric AED/CPR and First Aid. These trained student instructors could provide free training for low income community members as part of a special Red Cross program. This arrangement would allow the NU trained student instructors to also to provide training for students and other community members at a special rate. The NU Red Cross instructors could charge their trainees \$27 per course and the Red Cross would only charge the NU program \$10 per trainee. The difference of \$17 per trainee could be used as a revenue stream for the NU Community Health Corps. Several student members of the NU CHC provided leadership in researching and helping to develop this proposal. In Spring quarter 2016 one of these students used this opportunity as part of the course: Global Health: Achieving Global Impact Through Local Engagement. One of the most important aspects of this program, is that the NU Community Health Corps agreed to sponsor the Red Cross initiative and later integrated the initiative as a core part of their program. By the end of the summer 2016, a partnership Agreement had been formally proposed to both Northwestern University and the American Red Cross. Funding in the amount of \$5,350 was



secured from International Program Development, Career Services, and an external source, to pay for the training of 20 students, and purchase the training materials and mannequins for the program. The Evanston Public Library agreed to store the materials for the program. In October 2016, the first 16 students were trained as official Red Cross Instructors.

The International Program Development staff led the process of securing official support from Northwestern University for this initiative. Working closely with the offices of the General Counsel for legal and insurance compliance, on 3 April 2017, the Provost of Northwestern signed the official Partnership Agreement. Following this approval, similar partnership agreements were signed between Northwestern University International Program Development and the McGaw YMCA and the Evanston Public Library to provide training at no cost to low income members of the Evanston, Skokie and Chicago communities. The Red Cross Association of Greater Chicago and Northern Illinois continued to provide technical support to the NU CHC trained instructors. And the McGaw YMCA program staff enthusiastically embraced this initiative. Efforts are currently underway to secure additional partnerships with the Skokie Public Library and other community organizations. The Red Cross initiative has now been through three leadership changes and several training sessions have been completed for low income community groups.

### ***Chinatown Health Information Resource Centers***

For more than ten years, Chinese speaking Northwestern University students volunteered as translators with the Chinatown community health clinic. This clinic was sponsored and supported by the Northwestern Feinberg School of Medicine. In 2017 the community clinic was closed, and the Northwestern students tried to find other resources that could address the health needs of especially the low-income Chinese speaking residents. Several of these students

participated in global health courses at Northwestern and were either members of the NU Community Health Corps or participated in some of their events. These students met with several health serving organizations in Chinatown such as the Chicago Chinatown Public Library and secured their support. The Chinatown Public Library learned of the Health Information Resource Centers in Evanston and Skokie and offered to host such a center in their facility. In Fall 2017, these students made a formal presentation to the NU Community Health Corps Executive Board and requested sponsorship of the extension to Chinatown. In the same way that the Executive Board approved the Red Cross initiative to become an integral part of the NU Community Health Corps, the Chinatown Health Information Resource Center was approved as an integrated program. One of the student leaders of the Chinatown program was appointed as a member of the NU CHC Executive Board. Although many different types of relationships were explored such as a franchise, or partnership, or a project, the integration of the Chinatown Center was the best result possible. Further, the materials that have been produced for the HIRCULES Health Hub are now available to the Chinatown Health Information Resource Center. The students volunteered to translate all these materials into Mandarin. And the Red Cross program agreed to provide free Adult and Pediatric AED/CPR and First Aid training to the low-income community members of Chinatown.

### ***Conclusion***

These examples of collaborative programs demonstrate how barriers to qualified, culturally competent, trusted health information and appropriate, affordable health services can be overcome through resources that already exist in a community. Public, private and civil society sector organizations and institutions can significantly increase their impact on improving access to health information and services and improve people's knowledge of their health issues

and how to manage them, by sharing their resources. By taking an asset-based approach, communities can become more empowered to support their residents. But having the resources is not sufficient by itself. Collaboration benefits from an enabling environment in which the 5C's framework can be applied. When a common interest has been identified; there is a willingness to cooperate and to coordinate; communication channels are open, all that is needed is a catalytic leader or organization that can bring these resources together and has the energy and commitment to purposefully design and implement collaborative programs.

Since the barriers to improving access to information and services are still strong in communities such as Austin, the City of Chicago, and Evanston and Skokie, there is stress on the residents which as we have seen in Chapter 3 results in physiological responses that promote health issues related to Metabolic Syndrome. This stress can be relieved, and hypertension controlled through these collaborative health programs. Another method for assessing the impact of a collaborative partnership on Metabolic Syndrome is to evaluate the blood pressure levels of participants in the program as hypertension is a key indicator as we will see in Chapter 6.

## CHAPTER 6 QUANTITATIVE ANALYSIS

Hypertension is among the criteria used for clinical diagnosis of Metabolic Syndrome (Grundy, 2016; Grundy et al., 2004; Han & Lean, 2015; Vassallo, Driver, & Stone, 2016). Hypertension is a factor in the development of adult onset diabetes – Type 2; cardiovascular disease; stroke; heart attack; and end stage renal disease (Singh & Kari, 2013; Thomas et al., 2011). It has long been established that African Americans have a disproportionately higher incidence of diabetes, cardiovascular disease, diabetic nephropathy, end stage renal disease, blindness secondary to retinopathy, and a higher rate of nontraumatic lower extremity amputations compared to the general population and especially their White counterparts (Hill-Briggs et al., 2005). Hypertension is one of these specific indicators of metabolic syndrome and has been demonstrated to directly increase the risk for cardiovascular disease, especially for people over the age of 60 years (Benjamin et al., 2017; Crimmins, Hayward, Ueda, Saito, & Kim, 2008; Mozaffarian et al., 2015; National Center for Health Statistics, 2017a; Yoon, 2015). (See also Table 17). As we have seen in Chapter 2, these disparities also apply to the people in Chicago and especially to the people in the Austin community (See Table 2) (Chicago Department of Public Health, 2016a; Cohen, 2011).

Since 2012, weekly blood pressure and pulse measurements were taken of the participants in the collaborative health education program organized by Loretto Hospital at the Austin Community Satellite Center with financial support from the City of Chicago Department of Family and Support Services. These measurements were taken by a health professional, either a physician or a nurse, affiliated with Loretto Hospital, recorded and stored at Loretto Hospital and shared with the Chicago Department of Family and Support Services. Any person who came to the Austin Senior Center was eligible to have their measurements taken.

Of the nineteen participants active in the study from the Austin Senior Center, nine had attended these weekly meetings for up to five years from 2012-2017. These participants agreed to share their measurements as part of the study, and both Loretto Hospital and the City of Chicago Department of Family and Support Services agreed to release the data. On December 5, 2017, two hundred eleven records from these nine participants were provided for analysis. IBM SPSS Statistics Version 25 was used for the analysis of the data.

The 2017 revised American College of Cardiology/American Heart Association hypertension guidelines proposed for pharmacological treatment sets two Blood Pressure (BP) thresholds. The target BP for all pharmacologically treated hypertensives is  $\leq 130/80$  mm Hg and specifically  $>130$  mm Hg systolic in those 65 or older. The new guidelines consider BP of 130-139 systolic or 80-89 diastolic as stage I hypertension, and those with a BP of  $\leq 140$  or  $>90$  mm Hg as stage II hypertension (Whelton et al., 2018). For the purposes of this study hypertension was defined as having consistent BP readings of  $\geq 140/90$  mm Hg. (This follows the guidelines prior to the October 2017 change.)

### ***Results***

Table 9 presents the descriptive statistics for the 211 records obtained from the nine participants of the program. The mean age of the participants at the time of the study was 72.7 years. The ages of the participants ranged from 55 to 96 years, with the group being composed of 1 male and 8 females, all African Americans. For the entire sample, systolic and diastolic blood pressures average 137.7 and 78.7 mmHg, respectively, whereas pulse rates average 76.8 beats/min.

Table 9 Mean Age, Systolic and Diastolic Blood Pressures and Pulse for the 9 Adult Participants of the Austin Community Health Center Health Education Program

	N	Min	Max	Mean	Std. Dev.
Systolic BP (mm Hg)	211	95	177	137.7	14.5
Diastolic BP (mm Hg)	211	51	101	78.7	8.6
Pulse (Beats/min)	177	0	107	76.8	12.3
Age (years)	211	55.1	96.1	72.7	8.7

Descriptive measurements of systolic and diastolic Blood Pressure and Pulse by Age Group are presented in Table 10

Table 10 Age differences in systolic and diastolic blood pressure and pulse rates in the participants of the Austin Community Health Center Health Education Program

	Age	N	Mean	Std. Dev.
Systolic BP (mm Hg)	50-59	21	129.62	14.7
	60-69	54	139.87	14.5
	70-79	107	137.89	14.2
	80-89	21	132.90	10.6
	90-99	8	153.25	11.4
	Total	211	137.66	14.5
	Diastolic BP (mm Hg)	50-59	21	84.71
60-69		54	80.46	8.2
70-79		107	77.38	8.4
80-89		21	75.95	7.8069
90-99		8	75.88	7.93613
Total		211	78.70	8.56688

Pulse (beats/min)		50-59	19	78.95	15.33505
		60-69	44	71.80	7.89047
		70-79	86	79.10	13.88527
		80-89	21	76.62	7.58601
		90-99	7	74.71	7.58758
		Total	177	76.80	12.26416

Analysis of variance (ANOVA) in Table 11 shows that systolic and diastolic blood pressures vary significantly across age groups ( $p < 0.001$ ). For pulse measurements the differences are significant at  $p < 0.05$ .

Table 11 Analysis of Variance Systolic, Diastolic BP and Pulse by Age Group

		Sum of Squares	df	Mean Square	F	Sig.
Systolic (mmHg)	Between Groups	4046.423	4	1011.606	5.204	0.001
	Within Groups	40043.009	206	194.384		
	Total	44089.431	210			
Diastolic	Between Groups	1335.361	4	333.840	4.885	0.001
	Within Groups	14076.829	206	68.334		
	Total	15412.190	210			
Pulse	Between Groups	1677.534	4	419.383	2.909	0.023
	Within Groups	24794.546	172	144.154		
	Total	26472.079	176			

Table 12 presents the variation in mean of systolic and diastolic blood pressure measurements for each of the 9 participants.

Table 12 variation in mean of systolic and diastolic blood pressure measurements for each of the 9 participants

	Participant	N	Mean	Std. Dev.
Systolic BP (mmHg)	1	46	135.78	16.5
	2	22	139.23	13.3
	3	27	140.81	13.9
	4	21	123.67	10.3
	5	8	153.25	11.4
	6	13	142.46	18.3
	7	36	135.39	9.4
	8	6	144.83	13.3
	9	32	141.16	12.0
	Total	211	137.66	14.5
Diastolic BP (mmHg)	1	46	74.78	9.1
	2	22	75.55	6.8
	3	27	81.70	6.9
	4	21	84.00	8.5
	5	8	75.88	7.9
	6	13	82.08	11.2
	7	36	77.33	7.6
	8	6	87.33	4.9
	9	32	79.75	6.7
	Total	211	78.70	8.6
Pulse (beats/min)	1	40	74.18	14.1
	2	17	87.18	6.4
	3	21	90.67	10.9
	4	18	86.39	8.8
	5	7	74.71	7.6
	6	8	70.50	3.5
	7	31	72.16	5.0
	8	6	60.50	2.6
	9	29	68.93	5.8
	Total	177	76.80	12.3



Table 13 shows the analysis of variance of these systolic and diastolic BPs and pulse and indicates that there is a significant variance less than .001 ( $p < 0.001$ ).

Table 13 Variation in Mean Systolic, and Diastolic BP Across 9 Participants

		Sum of Squares	df	Mean Square	F	Sig.
Systolic BP (mmHg)	Between Groups	7726.662	8	965.833	5.365	.000
	Within Groups	36362.769	202	180.014		
	Total	44089.431	210			
Diastolic BP (mmHg)	Between Groups	2520.148	8	315.018	4.936	.000
	Within Groups	12892.042	202	63.822		
	Total	15412.190	210			
Pulse (beats/min)	Between Groups	12203.905	8	1525.488	17.962	.000
	Within Groups	14268.174	168	84.930		
	Total	26472.079	176			

Table 14 presents the pair-wise correlations of systolic and diastolic blood pressure and pulse rate measurements with age. The results demonstrate that systolic blood pressure significantly increases with age in this sample ( $r = 0.16$ ;  $p < 0.05$ ), whereas diastolic BP significantly declines with age ( $r = -0.24$ ;  $p < 0.01$ ). In contrast, pulse rates do not significantly vary with age in this sample. (For a complete pair-wise correlation of systolic and diastolic blood pressure and pulse rate measurements for each participant see Appendix 5.)

Table 14 Pairwise correlations of systolic and diastolic BP and pulse with age

		Systolic	Diastolic	Pulse	Age
Systolic	Pearson Correlation	1	.477**	-0.110	.161*
	Sig. (2-tailed)		0.000	0.144	0.019
	N	211	211	177	211
Diastolic	Pearson Correlation	.477**	1	0.041	-.238**
	Sig. (2-tailed)	0.000		0.588	0.000
	N	211	211	177	211
Pulse	Pearson Correlation	-0.110	0.041	1	0.062
	Sig. (2-tailed)	0.144	0.588		0.415
	N	177	177	177	177
Age	Pearson Correlation	.161*	-.238**	0.062	1
	Sig. (2-tailed)	0.019	0.000	0.415	
	N	211	211	177	211

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

To evaluate the percentage of systolic blood pressure measurements that were below the standard for Hypertension of 140mm Hg, a crosstabulation test was performed on the total number of systolic blood pressure records by age group. Table 15 shows the variation in rates of elevated systolic BP across the age groups. For the entire sample 45.5% of all records were above the Hypertension standard for systolic blood pressure of 140 mm Hg. The chi-square analysis in Table 16 shows that the rates of elevated systolic BP vary significantly by age group ( $p = 0.013$ ), with the lowest rates being observed among the 50-year olds (24%), and the highest rates being seen in the 70-year olds (88%).

Table 15 Crosstabulation of Systolic High Blood Pressure Above and Below 140 mm Hg by Age Group

			Age Groups					Total
			50-59	60-69	70-79	80-89	90-99	
SystolicHi	(below 140 mmHg)	Count	16	25	61	14	1	117
		Expected Count	11.6	29.9	59.3	11.6	4.4	117.0
		% within SystolicHi	13.7%	21.4%	52.1%	12.0%	0.9%	100.0%
		% within age groups	76.2%	46.3%	57.0%	66.7%	12.5%	55.5%
		% of Total	7.6%	11.8%	28.9%	6.6%	0.5%	55.5%
	(above 140 mmHg)	Count	5	29	46	7	7	94
		Expected Count	9.4	24.1	47.7	9.4	3.6	94.0
		% within SystolicHi	5.3%	30.9%	48.9%	7.4%	7.4%	100.0%
		% within age groups	23.8%	53.7%	43.0%	33.3%	87.5%	44.5%
		% of Total	2.4%	13.7%	21.8%	3.3%	3.3%	44.5%
Total	Count	21	54	107	21	8	211	
	Expected Count	21.0	54.0	107.0	21.0	8.0	211.0	
	% within SystolicHi	10.0%	25.6%	50.7%	10.0%	3.8%	100.0%	
	% within age groups	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of Total	10.0%	25.6%	50.7%	10.0%	3.8%	100.0%	

Table 16 Chi-Square Analysis of Elevated Systolic BP Rates

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	12.637 <sup>a</sup>	4	0.013
Likelihood Ratio	13.394	4	0.010
Linear-by-Linear Association	1.585	1	0.208
N of Valid Cases	211		

a. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 3.56.

Figure 7 shows the variation in percentage (%) of measurements with elevated systolic BP greater than or equal to 140 mm Hg) across age groups. The rates vary significantly by age ( $p = 0.013$ ), with systolic pressure being the highest in the oldest age group.

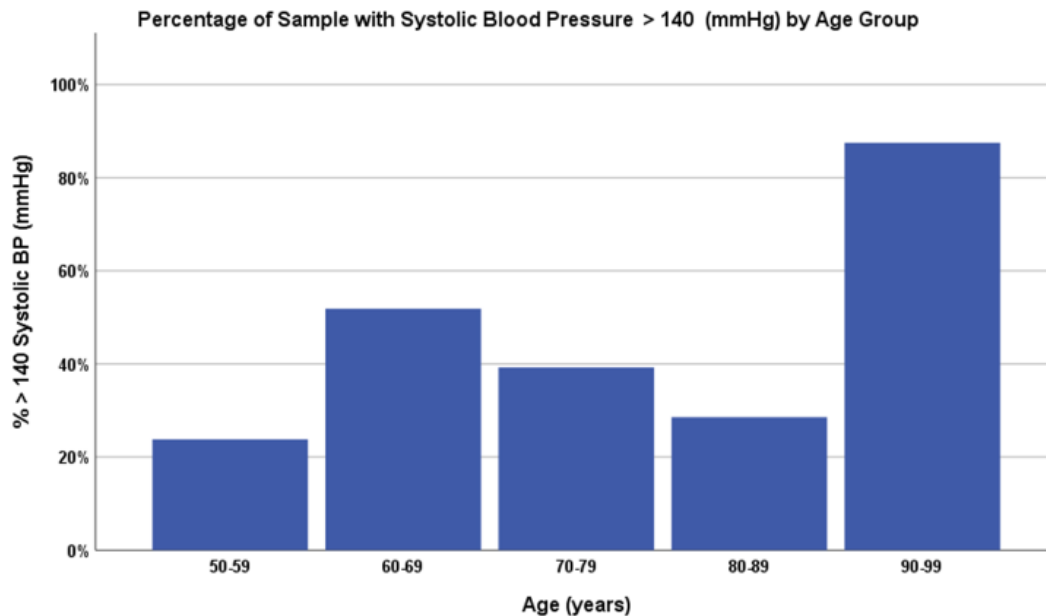


Figure 7 Percentage (%) of sample with systolic blood pressure greater or equal to than 140 mm Hg by age group.

To evaluate the percentage of diastolic blood pressure measurements that were below the standard for Hypertension of 90mm Hg, a Crosstabulation test was performed on the total number of diastolic blood pressure records by age group. Table 17 shows the variation in rates of diastolic BP across the ages groups. For the entire sample 9% of all records were above the Hypertension standard for diastolic blood pressure of 90 mm Hg. The chi-square analysis in Table 18 shows that the rates of elevated diastolic BP significantly decline by age group ( $p = 0.016$ ). Among 50-year-olds, the rates of elevated diastolic BP were 29%, as compared to 9%, 6%, 10% and 0% in the 60, 70, 80 and 90-year-old groups, respectively.

Table 17 Crosstabulation of diastolic high blood pressure above and below 90 mm Hg by age group

			Age Groups					Total
			50-59	60-69	70-79	80-89	90-99	
Diastolic Hi	.00 (below 90 mmHg)	Count	15	49	101	19	8	192
		Expected Count	19.1	49.1	97.4	19.1	7.3	192.0
		% within Diastolic Hi	7.8%	25.5%	52.6%	9.9%	4.2%	100.0%
		% within age groups	71.4%	90.7%	94.4%	90.5%	100.0%	91.0%
		% of Total	7.1%	23.2%	47.9%	9.0%	3.8%	91.0%
	1.00 (above 90 mmHg)	Count	6	5	6	2	0	19
		Expected Count	1.9	4.9	9.6	1.9	.7	19.0
		% within Diastolic Hi	31.6%	26.3%	31.6%	10.5%	0.0%	100.0%
		% within age groups	28.6%	9.3%	5.6%	9.5%	0.0%	9.0%
		% of Total	2.8%	2.4%	2.8%	0.9%	0.0%	9.0%
Total		Count	21	54	107	21	8	211
		Expected Count	21.0	54.0	107.0	21.0	8.0	211.0
		% within Diastolic Hi	10.0%	25.6%	50.7%	10.0%	3.8%	100.0%
		% within age groups	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	10.0%	25.6%	50.7%	10.0%	3.8%	100.0%

Table 18 Chi-Square Test of Diastolic BP Above and Below 90 mmHg by Age Group

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	12.122 <sup>a</sup>	4	0.016
Likelihood Ratio	9.834	4	0.043
Linear-by-Linear Association	6.532	1	0.011
N of Valid Cases	211		
a. 4 cells (40.0%) have expected count less than 5. The minimum expected count is .72.			

Figure 8. shows the percentages of diastolic blood pressure measurements that were above the standard for hypertension of 90 mm Hg across age groups.

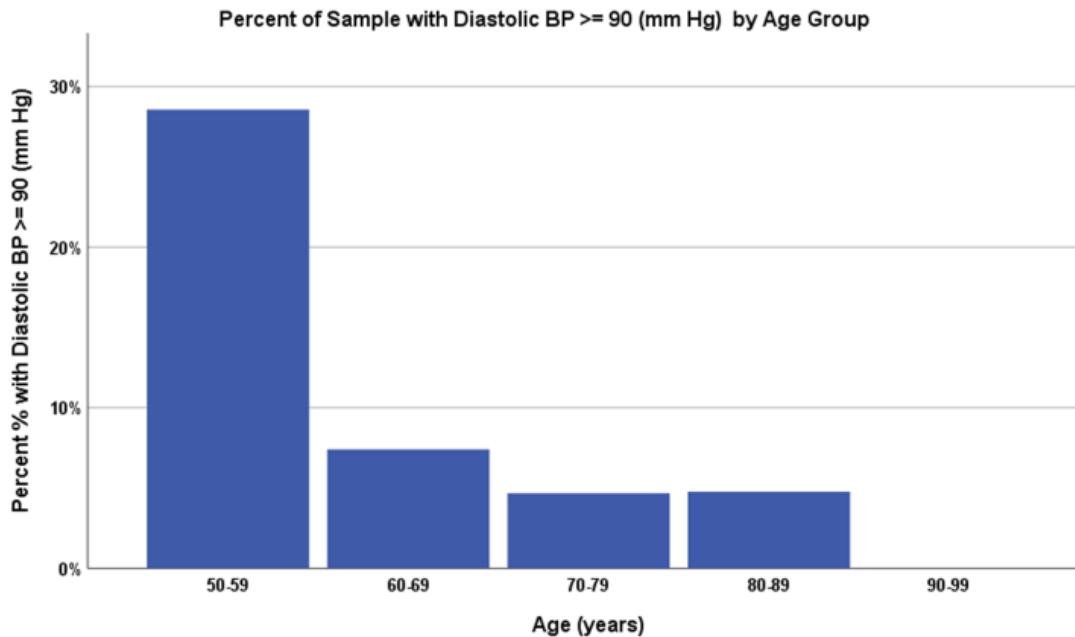


Figure 8 Percentage (%) of sample with diastolic BP greater than or equal to 90 mm Hg by age group

According to the 2016 report submitted by the Secretary of Health and Human Services and compiled by the US Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), for the period 2011-2014, 30.4% of all participants over the age of 20 years (age adjusted) had hypertension (as measured high blood pressure over 140/90 mmHg and/or taking antihypertensive medication)<sup>2</sup>.(National Center for Health Statistics, 2017a, 2017b) 43.3% of African Americans over the age of 20 years were found to be hypertensive.

<sup>2</sup> In this study, Hypertension is defined as having measured systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg. Those with high blood pressure may also be taking medicine for high blood pressure. In 2011-2014 85% of participants had three systolic or diastolic blood pressure readings.

During this same period 2011-2014 54.9% of all males from age 55-64 had hypertension; 63.4% of all males 65-74 years of age were hypertensive; and 72.3% of all males 75 years or older were hypertensive. For females during the same period 2011-2014, the study found that 52.1% of all females from age 55-64 had hypertension; 64.3% of females 65-74 years of age were hypertensive and 79.9% of all females 75 years or older were hypertensive. (Table 1) (National Center for Health Statistics, 2017a, 2017b). The statistics for those participants with uncontrolled high blood pressure with hypertension during the same period 2011-2014 were higher. 52.% of all participants had hypertension; 58.7% of all African Americans over the age of 20 (age adjusted) had hypertension. And during this same period 2011-2014, 51.7% of all males from 55-64; 38.2% from 65-74 and 46.5% over the age of 75 were found to have hypertension. For women from ages 55-64 34.8%; from 65-74 44.5%; and for women over the age of 75 61.5% were found to have hypertension.

Table 19 Extracted Data from National Health and Nutrition Examination Survey 2011-2014

Table 54 Hypertension among adults aged 20 and over, by selected characteristics: United States, selected years 1988–1994 through 2011–2014

Sex, age, race and Hispanic origin <sup>1</sup> , and percent of poverty level	Hypertension <sup>2,3</sup> (measured high blood pressure and/or taking antihypertensive medication)				Uncontrolled high blood pressure among persons with hypertension <sup>4</sup>			
	1988–1994	1999–2002	2007–2010	2011–2014	1988–1994	1999–2002	2007–2010	2011–2014
20 years and over, age-adjusted <sup>5</sup>	Percent of population							
Both sexes <sup>6</sup> . . . . .	25.5	30.0	30.6	30.4	77.2	70.6	55.8	52.8
Male . . . . .	26.4	28.8	31.3	31.0	83.2	73.3	61.4	58.1
Female . . . . .	24.4	30.6	29.6	29.7	68.5	61.8	46.3	45.5
Black or African American only . . . . .	38.1	42.3	42.7	43.3	77.5	71.5	59.7	58.7
Black or African American only, male . . . . .	37.5	40.6	40.5	42.4	84.0	74.3	71.5	66.2
Black or African American only, female . . . . .	38.3	43.5	44.3	44.0	71.1	67.2	51.0	52.8
Male								
Percent of population								
55–64 years . . . . .	40.6	45.0	49.5	54.9	70.3	55.9	46.7	51.7
65–74 years . . . . .	54.4	59.6	64.1	63.4	74.3	59.1	42.2	38.2
75 years and over . . . . .	60.4	69.0	71.7	72.3	82.5	74.3	50.7	46.5
Female								
55–64 years . . . . .	42.6	53.9	50.4	52.1	64.3	60.0	46.1	34.8
65–74 years . . . . .	56.2	72.7	69.3	64.3	68.7	73.5	44.9	44.5
75 years and over . . . . .	73.6	83.1	81.3	79.9	81.9	78.1	56.0	61.5

SOURCE: NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

In all cases, the percentage of African American participants with hypertension exceeded those of the general population and other demographic categories. So, it was to be expected that the blood pressure measurements of participants in the Austin Community Health Center Health Education program would have similarly high blood pressures that exceed the definition for Hypertension of blood pressure rates of >140/90 mm Hg.

In Figures 9 and 10, an analysis of the percentage of Participants with Systolic and Diastolic Hypertension over 140/90 mm Hg by NHANES Ages Group are presented. In this analysis the participants from 55 - 64 years of age had Systolic Hypertension (over 140 mm Hg) in only 40% of the cases as compared with the NHANES sample of 52.1%; in the 65-74 year age group 53% of the participants measured above 140 mm Hg compared with the NHANES sample of 64.3 %; and in the 75+ years age group, 43% of the participants measured above 140 mm Hg as compared with the national sample of 79.9

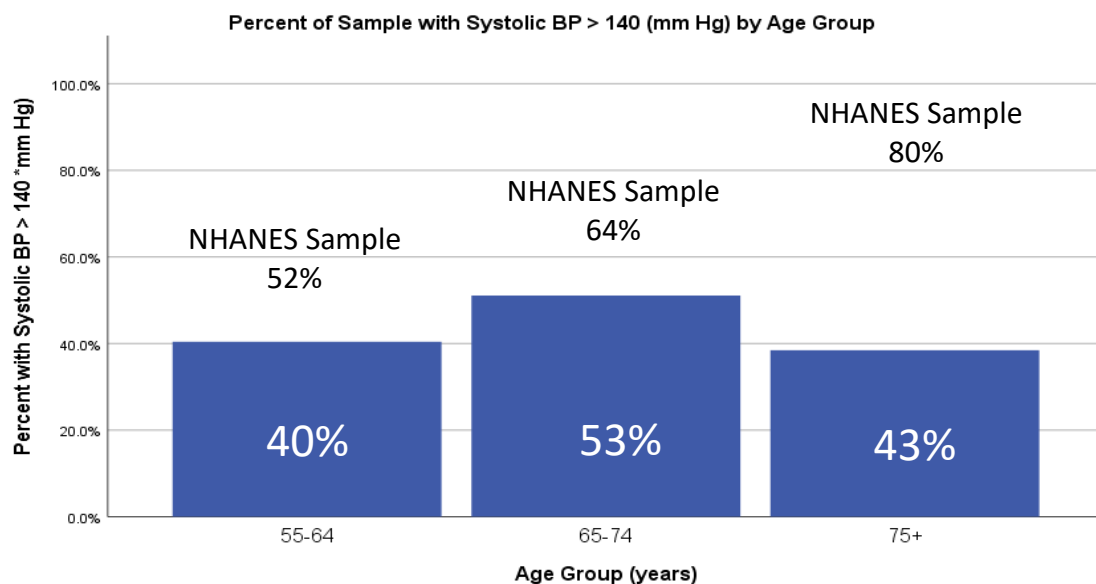


Figure 9 Percentage (%) of sample with systolic blood pressure >140 mm Hg by NHANES age groups



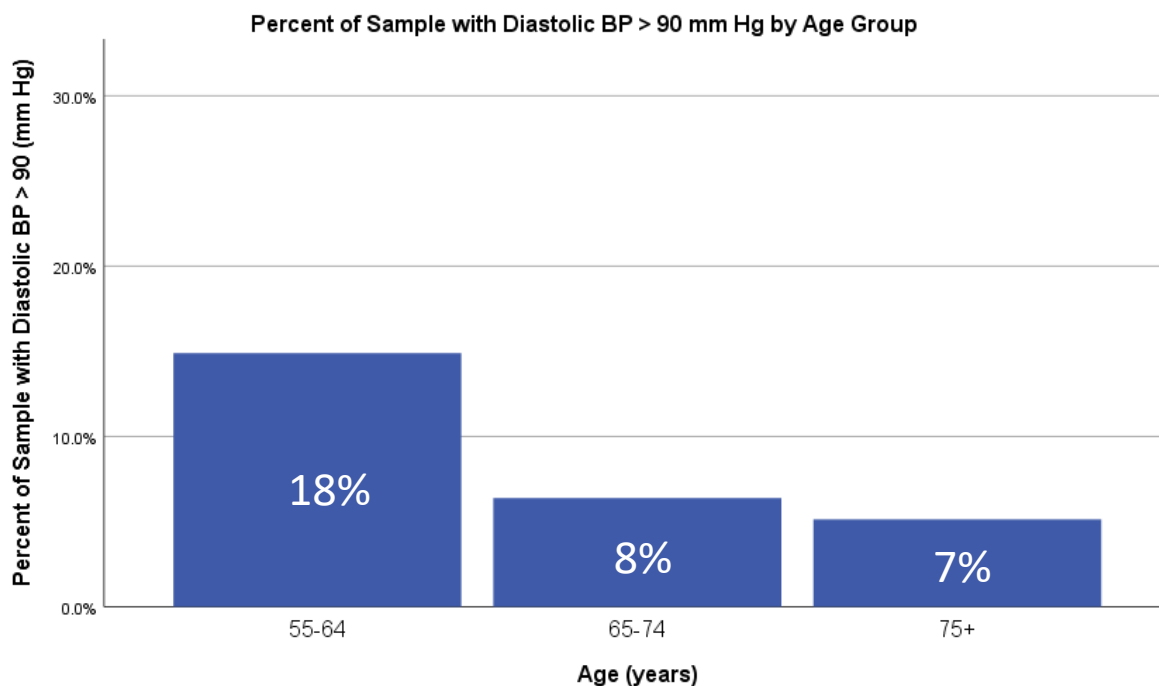


Figure 10 Percentage (%) of sample with diastolic blood pressure >90 mm Hg by NHANES age groups

### ***Conclusion***

The quantitative data analysis demonstrates the validity of the sample blood pressure measurements which reflect comparable trends of similar age and ethnicity. With an increase in age, there are significant normative trends towards higher systolic blood pressure measurements and towards lower diastolic blood pressure measurements. The significant result in these samples is that the mean systolic measurement is 138 $\pm$  15 mm Hg, and the diastolic measurements are 79  $\pm$  9 both of which are below the national standard for hypertension at 140 mm Hg systolic and 90 mm Hg diastolic. 55.5% of the systolic Blood pressure measurements were below the national standard for Hypertension and 91% of the diastolic measurements were below the Hypertension standard. (Ervin, 2009; National Center for Health Statistics, 2017b)

With respect to the national samples for these age groups and ethnicity for the period 2011- 2014

(Table 15), the results of the crosstabulation of systolic high blood pressure above and below 140 mm Hg by Age Group demonstrate that 45.5% of the Austin samples for Black or African Americans 20 years and over, age adjusted, met the criteria for Hypertension of 140/90 mm Hg compared with 58.7% in the NHANES population for both males and females. (See Figures 9 and 10)

The conclusion from the Austin sample is that participation in the health education program and other services at the Austin Senior Satellite Center linked with qualified medical providers from Loretto Hospital have an impact on reducing hypertension among African Americans over the age of 50 years.

## CHAPTER 7

### CONCLUSIONS, LESSONS LEARNED AND IMPLICATIONS FOR FUTURE STUDIES

There are no simple solutions to preventing and managing chronic diseases such as Metabolic Syndrome. Medication, education, behavior change, exercise, diet, timely access to qualified health information and services, safer, clean and enabling environments are all helpful tools for people to prevent illness and more effectively manage their health. However, the barriers to access these tools, especially for population groups at risk in low income areas, minorities, elderly, people with limited resources, targets of discrimination and racism and those who live in communities that are structurally violent, can be very difficult to overcome. The result of these barriers is a higher degree of health disparities and mortality rates. Of special interest to this study are the people living in the Austin community of Chicago with a high rate of health issues related to Metabolic Syndrome. And while there is no panacea for preventing or resolving these issues, there is evidence that collaboration between public, private and civil society organizations with a focus on a common goal of improved health, can effectively improve the health outcomes of people living in these communities. When applying an asset-based approach to any community, such as the Austin community of Chicago, it becomes clear how many resources are available to address challenges such as improving health status and the quality of life. Even in communities that are facing decades of structurally imposed barriers that negatively affect the social determinants of health, people are resilient and work hard to build and strengthen relationships and institutions.

In this study, I examined the impact of an organized, purposeful collaboration between the city of Chicago, a local community hospital and a locally managed civic center on the health issues that are related to metabolic syndrome. The intent of the study was to determine whether

such a collaboration could increase access to qualified health information, timely, appropriate and affordable services and result in improved health status. As outlined in Chapter 1, some of the most persistent and growing health problems of people in the Austin community, which compromise the quality of their lives and reduce life expectancy, are related to the increasing incidence of metabolic syndrome. And these health problems are exacerbated by social, economic and political factors such as the structural exploitation of the people in their housing, education, access to fresh, nutritious and affordable foods, and the disempowerment of their existing institutions by external forces that are more concerned with the profits to be gleaned from the community. In Chapter 2, I described the history of the Austin community and its shift from a majority white population to a majority African American and Black population. In Chapter 3, I explored the relationship of structural exploitation to the health issues related to Metabolic Syndrome such as diabetes, cardiovascular disease, obesity, kidney and liver diseases. There is considerable evidence that demonstrates the health consequences of this relationship. Chapter 4 described the anthropological methods used and defined the scope of the study through participant/observation, description and analysis, ethnographic interviews and examination of the socio-ecological environment in which the study took place. These methods were used to study the impact of a collaborative multi-sector program in providing increased access to qualified health information and appropriate service on stress and hypertension, which are two factors in Metabolic Syndrome. A framework for effective collaboration on health programs was presented, called the 5 C's. This framework provides a coherent set of approaches to promote effective collaboration. These can lead to more effective program design, implementation and policy recommendations that focus more on empowering people to improve the quality of their lives and communities rather than generating increased revenue. In Chapter 5, I applied an

ethnographic and survey analysis of the Austin Senior Satellite Center and the Christ Tabernacle Missionary Baptist Church and presented the study comparing three groups of participants: the people who attended the Austin Senior Satellite Center and participated in the collaborative weekly, health education program with Loretto Hospital; the people who attended the Austin Senior Satellite Center and participated in other activities; and the people who are members of the Christ Tabernacle Missionary Baptist Church of Austin, and did not participate at the Austin Senior Satellite Center. The conclusion from the analysis of the three groups provides evidence of the impact of the collaboration between Loretto Hospital and the Austin Senior Center. The weekly health education program at the Austin Senior Center showed evidence of lower stress, better health information and increased opportunities for a combination of socialization, community engagement, access to health information and appropriate services. Further, several other examples of collaborative programs that improved access to health information and services was presented. The results demonstrate that even in communities affected by structural barriers, there are resources that can be effectively shared through such cooperative programs. What is needed is a common goal, a willingness to cooperate and to coordinate the sharing of their resources, open communication channels and an enabling environment led by catalytic leaders. Chapter 7 provided a description and quantitative analysis of the blood pressure measurements of the group of people who participated in the collaborative health education program over a period of 5 years. The analyses showed that this group of African Americans over the age of 50 years, had blood pressure measurements that were hypertensive but were significantly lower than the national average for this same population group. Regular participation in the Austin Senior Satellite Center, and especially at the weekly health education meetings appear to be a factor in these outcomes. Further research is needed to examine other

factors such as the resilience of the individuals in each group. There may be other personal factors that differentiate or have an impact on the health seeking strategies that these different groups of people use to manage their health. The evidence presented in this study shows the importance of a safe and supportive environment in which people can socialize, exercise, and engage in community social and political events. And having trusted, culturally competent, qualified health professionals who are linked to a community health center reduces stress, helps to control hypertension, increases knowledge of personal and family health issues and improves access to appropriate and affordable health services.

### ***Best Practices and Lessons Learned***

Collaboration between public, private and civil society sectors is an effective framework to coordinate the sharing of resources, services, information, and improve access to patient centered, culturally competent, affordable care. In this study the collaboration was forged between the public sector – City of Chicago funding for the Austin Senior Satellite Center and its contract with Loretto Hospital to provide health education and other health related support services with a community-based organization – South Austin Community Coalition Council.

This study finds such collaboration provides qualified health information, and improved access to health and other social services such as pharmaceuticals, specialized medical services (e.g. dialysis or mental health), primary care, health insurance options, and support for utilities and housing.

Stress has a significant impact on Metabolic Syndrome. A common refrain from people participating in the weekly health education programs was that their stress was reduced by attending these weekly sessions; having access to Janice Henry, who is a trusted source of information and referrals; having a safe environment in which to socialize and exercise; and

engage in community social and political events. This collaboration promotes a multi-faceted approach to health and wellness and provides opportunities to overcome political, economic, social and health barriers. The Austin Senior Center provides education, social opportunities, community-engagement to discuss, argue, protest, and demonstrate for social and health justice, helps to find resources that address specific health issues both personal and family, provides food and information for a healthy diet, and provides a safe, clean, warm/cool environment for exercise and socializing, which results in lower stress to the participants and helps them to control their hypertension.

An asset-based approach to community health identifies the community-based resources that are available to people living in low income communities. These community health issues are not necessarily related to a lack of resources, but rather to the structural barriers and obstacles that restrict or prevent access to them. These are the social determinants such as having to work long hours which restricts access to the operating hours of most health services; costs of healthcare; harsh, inappropriate and racist treatment by the health providers; transportation costs; lack of affordable, accessible, nutritious foods and especially fresh vegetables and fruits; lack of safe, clean environments in which to exercise; lack of affordable medications which often force people to choose between their medication, rent, and food; lack of qualified information about health and available resources; and a lack of trust between the patients and providers.

These collaborations must be focused on the convergent interest of improving health outcomes and shift away from profit as the primary goal. It is inspiring to see what can be achieved when a community of people decide to work together to benefit and empower their people.

Trust is an essential component of any successful partnership and relationship. Trust between patients and providers, trust in civic leaders, and the integrity of institutions have to be strengthened.

A well-meaning, well-intentioned health program, especially those organized by community or faith-based organizations, should have a formal partnership with a medical provider to ensure consistent, qualified messages and information, and an understanding and identification of appropriate, affordable and accessible resources.

### ***Implications for Further Study***

The findings of this study suggest that there is a need to design and implement a larger scale prospective research project with baseline and regular biometric measurements, for each of three groups: 1) participants in collaborative programs; 2) participants in health education and monitoring programs especially in a collaborative partnerships between health providers, payers, faith based and other community organizations; and 3) a control group with not participating in any collaborative health based partnership. The collaboration should have a formal partnership affiliation with a university research institute .

Applied medical anthropology is an important methodology in this research. Medical Anthropologists and other health researchers conduct observations, impact analysis of health status, health programs and make recommendations and suggestions for how to improve health outcomes. Applied Medical Anthropologists also participate in the design and implementation as well as evaluation of health programs. As noted above in Chapter 4, there are serious ethical implications for the application of these methods. These methods can be applied to manipulate people, and they can also be applied to encourage behavior and social/cultural changes. Many Medical Anthropologists consider these ethical values when working with different population



groups so as to engage and empower them rather than direct or impose their ideas or strategies. (Baer, 1996; Baer, Singer, & Susser, 1997; P. Farmer et al., 2013; Lindenbaum, 2013; Singer & Baer, 2012).

Applied medical anthropology can be an effective method of learning how to approach and work with vulnerable population groups and communities, and to share the results of other programs that are relevant to address the issues and barriers. Trust is an essential aspect of anthropological methodology and the sharing of knowledge can be an important method of empowering a community. Applied Medical Anthropologists can be the catalytic leaders that are essential to forming collaborative programs and for becoming effective advocates to promote and foster improved health outcomes in both local and global communities.

Janice Henry, the community nurse at Loretto Hospital, wanted to know how I was going to help the community as I studied their health. I worked closely with Janice to determine the best ways in which I could contribute. I assisted with her health education seminars. I organized graduate students to assist with the community health fairs that she organized. I also made myself available to Janice, and the other community leaders with whom I worked to respond as appropriate to whatever service they requested. With the Northwestern University Community Health Corps, we provided fresh fruit to children and their families at several annual Going Back to School Fairs that were organized by Rep. Danny Davis.

The results from this study will be shared with Janice Henry, State Rep. Camille Lilly, representatives of the South Austin Community Coalition Council and the leaders of the Christ Tabernacle Missionary Baptist Church. Hopefully, the results of this study can help to validate these programs that they provide to their communities and ensure their continuation. And if

possible to implement some of the recommendations such as expanding their services to other faith-based community organizations.

People matter as a critically important component of any health intervention strategy. The anthropological methods of qualitative ethnographic and quantitative analysis can be useful to engage people in their own studies to design and implement appropriate programs. This study identified some other questions which require further research and analysis.

Trust was identified as one of the most important criteria for working with vulnerable populations. Trust is an essential component of my approach to the community and resulted in access in some cases. But without this trust, my access was denied in other cases. What is trust? How is it to be achieved? What are the criteria for appropriate and successful engagement? Trust is also an important factor in the relationship between health providers and patients. How can trust be built and strengthened in providers? How can trust and its impact be measured?

Resilience is one of the goals of a successful health system. If people are resilient they can bounce back to health from illness or other crises. Some people are more resilient than others as can be seen from the participants in the three groups in this study. The people who participated in the weekly health education meetings benefitted from their participation but may also have other traits such as resilience which encouraged their participation. Further studies of their personal histories would help to understand their resilience and perhaps how to build and strengthen this trait in others, especially younger population groups.

A synthetic approach to health and wellness is needed to promote a multi-disciplinary, culturally competent, socio-ecological team analysis and understanding. These teams should include representatives from medicine, public health, Anthropology, Economics, Social Work, Community-engaged scholarship, community organizing, and members of the community. For

example, a much more detailed survey and analysis of people's economics is essential for assessing access to health care and services. A patient can receive a diagnosis and a prescription without an understanding of their ability to find the necessary follow up care or to pay for the services and drugs. There are many cases in the Austin community of people having to make decisions about whether to pay rent, or food or medicine/health care. This is one of the factors that results in the loss of homes and health complications. A multi-disciplinary approach using biometric and anthropological and other methods of research and analysis, will lead to greater understanding and more appropriate health program design.

Working with these seniors in this study was an extraordinary experience. Their health is changing, along with their metabolism and their lifestyles. In some cases, although they now have access to Medicare and Medicaid, their health was compromised before they turned 65. But young people before the age of 10 in the Austin community are beginning to suffer from health issues related to Metabolic Syndrome along with many other problems such as the difficulty to find nutritious and affordable foods, drugs, tobacco, sexual violence and abuse, gun violence, etc. Some of these young people begin to have heart disease and kidney issues and are on dialysis by the time they are 22 and are dead by the age of 28 (Janice Henry, personal communication). Some people are so obese they cannot get out of their homes to visit the doctor or clinic and must call the Fire Department to help move them down and up the stairs. These obesogenic environments require a call to action. These are not simply health care issues and require a purposeful approach to address these social determinants or structural violence that pose barriers to their hopefully longer, healthier lives.

**Advocacy and Public Policy:** After the collaborative programs have been designed and implemented, researched and analyzed, there are public policy and funding implications for

addressing community specific structural barriers and promoting health and wellness from a socio-ecological perspective. These implications should be included as a formal component of future studies.

Structural violence and social determinants compromise the lives and health of people living in the Austin Community. These barriers and obstacles can be overcome through community assets such as: the abundance of compassion, good will, faith, hope for a better life and future, hard work, dedication and willingness of community members, organizations, employers and some political leaders to organize and address them.

Catalytic leadership in each of the public, private and civil society sectors is key. Purposeful, serious, focused collaborations with convergent goals of improved health and quality of life does not happen by accident. Trusted, passionate, engaged leaders and organizations must act as the catalysts which promote these collaborative actions for the benefit of the people in the community. It is inspiring to see what can be achieved when a community of people decide to work together to empower their people.

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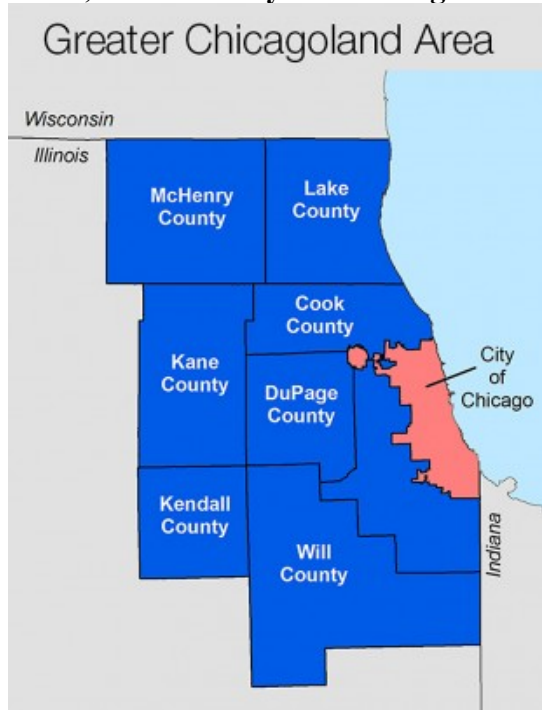
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## APPENDICES

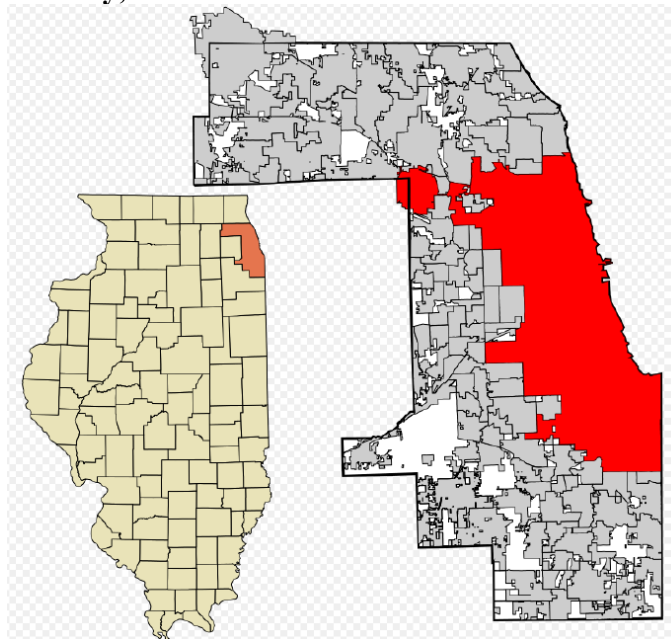
### Appendix 1

#### Map of Illinois, Cook County and Chicago



<https://today.uic.edu/real-time-talks>

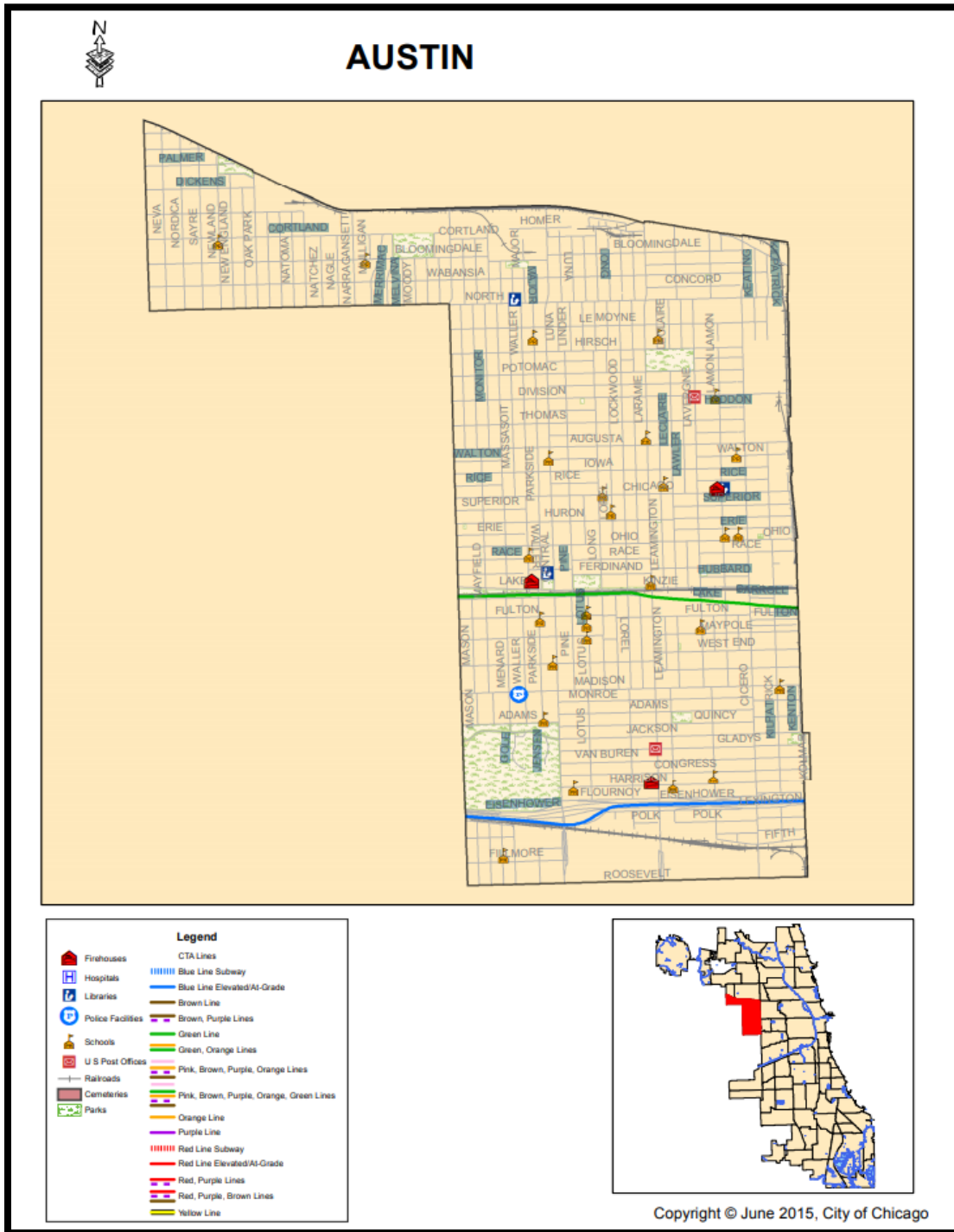
#### Chicago within Cook County, Illinois



Data source: [2010 U.S. Census](#)

# Appendix 2

## Map of the Austin Community of Chicago



## Appendix 3

### Recruitment Letter Seeking Participants in a Research Survey on Health in Chicago

Northwestern | ARTS & SCIENCES

Northwestern University  
Judd A. and Marjorie Weinberg College  
of Arts and Sciences  
Program in Global Health Studies  
1800 Sherman Ave  
Suite 4-400  
Evanston, Illinois 60201

globalhealth@northwestern.edu  
Office 847. 467. 0750

#### SEEKING PARTICIPANTS

#### Research Survey on Health in Chicago

Researcher: Michael Diamond, Northwestern University

If you are 50 years of age or older, you are invited to participate in a research study on health issues such as high blood pressure, diabetes type 2, high cholesterol and cardiovascular disease.

The rates of heart disease, obesity and diabetes type 2 continue to increase for all people in the United States. There are many people with these health issues living in Chicago communities. This study seeks to understand the ways that people understand and manage these illnesses in their community of Chicago.

The purpose of this study is to understand how people in this community deal with diabetes, heart disease and kidney disease. We seek to understand how people learn about these diseases, manage their health, where they go for treatment and how people use the health services that are available in the community.

Surveys will take about a half hour, and participants will receive a \$10 gift card after the survey is completed

If you are interested to participate or for more information, please contact:

Michael Diamond  
Northwestern University  
Michael-diamond@northwestern.edu  
847 679-0837

## Appendix 4

### Interview Questions – Community Members

Objective: To assess the health management strategies defined by people in the Austin community regarding their comprehension of risk factors for metabolic syndrome, access to qualified health information, timely access to community health services and their health outcomes.

Community members have personal health issues related to risk factors for metabolic syndrome and have different access to qualified health information and clinical services. They understand these risk factors, how to prevent or reduce them and have designed strategies to manage their health.

Demographic information: Adults over the age of 50 in the Austin Community of Chicago

Name

Address

Date of birth

Place of birth

How long have you lived in Austin?

Gender

Employment

Education level

Annual income/monthly income

Marital status

Children

How many people do you live with

Do you have any health issues?

I am especially concerned with diabetes and cardio-vascular disease.

Do you know what these are?

How would you explain these to your neighbor?

Diabetes

Cardio-vascular disease

Stroke

Heart attack

Chest pains

High blood pressure

Obesity

Smoking

Blood sugar levels

Risk factors

Healthy

- 1) How do you get your health information?
- 2) Do you have a health provider? Where do you go to manage your health issues?
- 3) Do you have insurance? Medicare? Medicaid? How else do you pay for your health needs?

- 4) What are the key messages you have received about heart disease, obesity, diabetes and each of these specific risk factors? What are some concerns you should watch for?
  - a. BMI
  - b. Waist circumference
  - c. Blood Pressure
  - d. HbA1c
  - e. HDL
  - f. Triglycerides
- 5) How do you think that these risk factors should be managed?
- 6) How do you measure your health? How do you know you are healthy?
- 7) If you or someone you know presents with three or more of these risk factors, what actions should they take? What do they need to do to lower their risk?
- 8) What do these conditions mean to you, and what do you think are the appropriate ways to respond?
- 9) Do you think that you or the other people you know are acting according to these recommendations? What should they be doing?
- 10) If you get sick, where do you get your qualified health information and clinical services?
- 11) How do other people in your family or who you know in the community access qualified health information and clinical services?
- 12) What do you think can be done to increase your access? What do you think needs to be done to increase access for other members of the community?
- 13) Do you think that the Affordable Care Act will have an impact on increasing access and reducing these risk factors?
  - a. Health insurance
  - b. Accountable Care Organizations
  - c. Patient Navigators, Health Insurance Navigators, Community Health Workers, coalitions?
- 14) How do you know when you are successful in lowering your risk factors? How do you measure your situation and progress?
- 15) What do you think needs to be done to lower these risk factors in the community?
- 16) How do you think that these risk factors can be prevented?
- 17) Questions about nutrition, diet, access to fresh foods
- 18) Questions about exercise.
- 19) If you have access to a health provider, how do they define these factors and how should they be managed?
- 20) Do you think that you or the other people you know are acting according to these recommendations? What should they be doing?

### Appendix 5 Pairwise correlations of Blood Pressure and Pulse with Age, of each Participant

Participant

Number

Correlations<sup>a</sup>

1		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.598**	-0.108	0.086
	Sig. (1-tailed)		0.000	0.254	0.284
	N	46	46	40	46
Diastolic BP (mmHg)	Pearson Correlation	.598**	1	0.021	0.238
	Sig. (1-tailed)	0.000		0.448	0.055
	N	46	46	40	46
Pulse (Beats/min)	Pearson Correlation	-0.108	0.021	1	.340*
	Sig. (1-tailed)	0.254	0.448		0.016
	N	40	40	40	40
Age	Pearson Correlation	0.086	0.238	.340*	1
	Sig. (1-tailed)	0.284	0.055	0.016	
	N	46	46	40	46

\*\* . Correlation is significant at the 0.01 level (1-tailed).

\* . Correlation is significant at the 0.05 level (1-tailed).



**Correlations<sup>a</sup>**

2		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.516**	0.248	-.387*
	Sig. (1-tailed)		0.007	0.168	0.038
	N	22	22	17	22
Diastolic BP (mmHg)	Pearson Correlation	.516**	1	-0.185	-0.141
	Sig. (1-tailed)	0.007		0.238	0.266
	N	22	22	17	22
Pulse (Beats/min)	Pearson Correlation	0.248	-0.185	1	-0.034
	Sig. (1-tailed)	0.168	0.238		0.448
	N	17	17	17	17
Age	Pearson Correlation	-.387*	-0.141	-0.034	1
	Sig. (1-tailed)	0.038	0.266	0.448	
	N	22	22	17	22

\*\* . Correlation is significant at the 0.01 level (1-tailed).

\* . Correlation is significant at the 0.05 level (1-tailed).

**Correlations<sup>a</sup>**

3			Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
	Systolic BP (mmHg)	Pearson Correlation	1	.566**	-0.082	-0.095
		Sig. (1- tailed)		0.001	0.362	0.318
		N	27	27	21	27
	Diastolic	Pearson Correlation	.566**	1	0.197	0.195
		Sig. (1- tailed)	0.001		0.196	0.165
		N	27	27	21	27
	Pulse	Pearson Correlation	-0.082	0.197	1	0.327
		Sig. (1- tailed)	0.362	0.196		0.074
		N	21	21	21	21
	Age	Pearson Correlation	-0.095	0.195	0.327	1
		Sig. (1- tailed)	0.318	0.165	0.074	
		N	27	27	21	27

\*\* . Correlation is significant at the 0.01 level (1-tailed).

**Correlations<sup>a</sup>**

4		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.499*	0.349	0.095
	Sig. (1-tailed)		0.011	0.078	0.341
	N	21	21	18	21
Diastolic BP (mmHg)	Pearson Correlation	.499*	1	0.154	0.040
	Sig. (1-tailed)	0.011		0.270	0.431
	N	21	21	18	21
Pulse (Beats/min)	Pearson Correlation	0.349	0.154	1	-0.256
	Sig. (1-tailed)	0.078	0.270		0.153
	N	18	18	18	18
Age	Pearson Correlation	0.095	0.040	-0.256	1
	Sig. (1-tailed)	0.341	0.431	0.153	
	N	21	21	18	21

\*. Correlation is significant at the 0.05 level (1-tailed).

a. Participant = 22

**Correlations<sup>a</sup>**

5		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.713*	0.126	-0.497
	Sig. (1- tailed)		0.023	0.394	0.105
	N	8	8	7	8
Diastolic BP (mmHg)	Pearson Correlation	.713*	1	-0.078	-0.117
	Sig. (1- tailed)	0.023		0.434	0.392
	N	8	8	7	8
Pulse (Beats/min)	Pearson Correlation	0.126	-0.078	1	-.695*
	Sig. (1- tailed)	0.394	0.434		0.042
	N	7	7	7	7
Age	Pearson Correlation	-0.497	-0.117	-.695*	1
	Sig. (1- tailed)	0.105	0.392	0.042	
	N	8	8	7	8

\*. Correlation is significant at the 0.05 level (1-tailed).

Correlations<sup>a</sup>

6		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.846**	-0.581	.774**
	Sig. (1- tailed)		0.000	0.065	0.001
	N	13	13	8	13
Diastolic BP (mmHg)	Pearson Correlation	.846**	1	-0.406	.790**
	Sig. (1- tailed)	0.000		0.159	0.001
	N	13	13	8	13
Pulse (Beats/min)	Pearson Correlation	-0.581	-0.406	1	-0.593
	Sig. (1- tailed)	0.065	0.159		0.060
	N	8	8	8	8
Age	Pearson Correlation	.774**	.790**	-0.593	1
	Sig. (1- tailed)	0.001	0.001	0.060	
	N	13	13	8	13

\*\* . Correlation is significant at the 0.01 level (1-tailed).

Correlations<sup>a</sup>

7		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	.723**	0.032	0.129
	Sig. (1- tailed)		0.000	0.432	0.226
	N	36	36	31	36
Diastolic BP (mmHg)	Pearson Correlation	.723**	1	-0.050	0.274
	Sig. (1- tailed)	0.000		0.394	0.053
	N	36	36	31	36
Pulse (Beats/min)	Pearson Correlation	0.032	-0.050	1	-0.257
	Sig. (1- tailed)	0.432	0.394		0.082
	N	31	31	31	31
Age	Pearson Correlation	0.129	0.274	-0.257	1
	Sig. (1- tailed)	0.226	0.053	0.082	
	N	36	36	31	36

\*\* . Correlation is significant at the 0.01 level (1-tailed).

Correlations<sup>a</sup>

8		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age
Systolic BP (mmHg)	Pearson Correlation	1	-0.179	0.439	-0.622
	Sig. (1- tailed)		0.367	0.192	0.094
	N	6	6	6	6
Diastolic BP (mmHg)	Pearson Correlation	-0.179	1	-0.157	-0.045
	Sig. (1- tailed)	0.367		0.383	0.466
	N	6	6	6	6
Pulse (Beats/min)	Pearson Correlation	0.439	-0.157	1	0.063
	Sig. (1- tailed)	0.192	0.383		0.453
	N	6	6	6	6
Age	Pearson Correlation	-0.622	-0.045	0.063	1
	Sig. (1- tailed)	0.094	0.466	0.453	
	N	6	6	6	6

**Correlations<sup>a</sup>**

9		Systolic BP (mmHg)	Diastolic BP (mmHg)	Pulse (Beats/min)	Age	
	Systolic BP (mmHg)	Pearson Correlation	1	.591**	-0.292	-0.043
		Sig. (1- tailed)		0.000	0.062	0.408
		N	32	32	29	32
	Diastolic BP (mmHg)	Pearson Correlation	.591**	1	0.126	0.096
		Sig. (1- tailed)	0.000		0.257	0.300
		N	32	32	29	32
	Pulse (Beats/min)	Pearson Correlation	-0.292	0.126	1	0.225
		Sig. (1- tailed)	0.062	0.257		0.120
		N	29	29	29	29
	Age	Pearson Correlation	-0.043	0.096	0.225	1
		Sig. (1- tailed)	0.408	0.300	0.120	
		N	32	32	29	32

\*\* . Correlation is significant at the 0.01 level (1-tailed).

a. Participant = 96