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Alliance for Cancer Care

Time Frame	1/2017-12/2021
Funder	Merck Foundation
PI	Melissa Simon, MD, MPH; Northwestern University
Alliance Site PI	Fred Rachman, MD
Health Centers	Near North Health Service Corporation, Howard Brown Health
Description	AllianceChicago is working with Dr. Melissa Simon at Northwestern University on a quality improvement project to improve processes around cancer care in the primary care setting. Primary care in CHCs is crucial for population healthcare delivery. However, patients facing a cancer diagnosis must seek care outside of this more familiar setting.
Objectives/ Goals/ Deliverables	1. To create models and approaches that bolster more connected integration between primary care and cancer care. 2. Work towards building capacity, protocols & knowledge of guidelines necessary to deliver the required spectrum of care. 3. Work towards optimizing the coordination of primary care and cancer care providers across the cancer care spectrum through cancer care plans that truly bridge the CPC with the specialty oncology team from the time of diagnosis going forward.

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CAPriCORN Asthma Cohort

Time Frame	3/2014 – 8/2018
Funder	Patient-Centered Outcomes Research Institute (PCORI)
PI	Chris Codispoti, MD, PhD; Rush University
Alliance Site PI	Fred Rachman, MD
Health Centers	Erie Family Health Center, Near North Health Service Corporation, Howard Brown Health
Description	As one of the disease cohorts in the CAPriCORN project, the asthma cohort proposes to identify patients with asthma in the participating CAPriCORN institutions, to approach identified patients with asthma and obtain consent, and then to administer a 25-minute survey to characterize their asthma, physical activity and sleep quality.
Objectives/ Goals/ Deliverables	1. To recruit 1000 patients with asthma and ascertain their interest in participating in future studies. 2. Use the results of the Asthma Survey to evaluate what demographic and health characteristics are associated with asthma control and risk for asthma exacerbations. 3. Use the results of the Asthma Survey to compare characteristics of asthma disease and demographics between obese and non-obese subjects with asthma. 4. Use the results of the Asthma Survey to evaluate whether the level of perceived satisfaction with sleep quality is associated with specific demographics and health characteristics among patients with asthma.

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CAPriCORN Weight Cohort

Time Frame	3/2014 – 8/2018
Funder	Patient-Centered Outcomes Research Institute (PCORI)
PI	Marian L. Fitzgibbon, PhD; University of Illinois at Chicago
Alliance Site PI	Fred Rachman, MD
Health Centers	Erie Family Health Center, Near North Health Service Corporation, Howard Brown Health
Description	As one of the disease cohorts in the CAPriCORN project, the weight cohort proposes to incorporate the collection of diet and physical activity data on a subsample of our cohorts to better characterize them. At AllianceChicago participating CHCs, we will be conducting surveys with patients that are eligible and consent to participate.
Objectives/ Goals/ Deliverables	1. Characterize patterns of overweight and obesity among adults receiving primary care at CAPriCORN sites, 2. Pilot test strategies to collect information on dietary intake, physical activity, and sedentary behavior in diverse samples of overweight and obese adults, and 3. Describe the dietary intake, physical activity, and sedentary behavior in those samples, and iteratively improve our characterization of this cohort.

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Chicago Area Patient-Centered Outcomes Research Network (CAPriCORN)

Time Frame	3/2014 – 8/2018
Funder	Patient-Centered Outcomes Research Institute (PCORI)
PI	Abel Kho, MD; Northwestern University
Alliance Site PI	Fred Rachman, MD
Health Centers	Alivio Medical Center, Erie Family Health Center, Heartland Health Centers, Heartland Health Outreach, Howard Brown Health, Near North Health Service Corporation, The Night Ministry, PCC Wellness, TCA Health, Inc.
Description	CAPriCORN, funded by PCORI, was developed to address significant health disparities due to variable access to high-quality care and differences in socioeconomic resources. CAPriCORN will seek to model how healthcare institutions in complex urban settings can overcome barriers of competition, care fragmentation, and limited resources to develop, test, and implement strategies to improve care for diverse populations and reduce health disparities.
Objectives/ Goals/ Deliverables	1. Capture clinical information in more than 1 million patients 2. Develop the capacity to efficiently conduct comparative effectiveness research (CER) trials and observational studies, including a fully operational central IRB 3. Establish procedures for clinical data standardization and inter-operability across the national patient-centered research network of clinical data research networks (CDRNs) and patient-powered research networks (PPRNs) 4. Engage patients, clinicians, and health system leadership in governance and use of CAPriCORN resources 5. Recruit and survey five cohorts (clostridium difficile, sickle cell, anemia, asthma, weight)

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Collaborations for Health and Empowered Community-based Scientists (CHECS) Project

Time Frame	7/2017 – 7/2019
Funder	Patient-Centered Outcomes Research Institute (PCORI)
PI	Nivedita Mohanty, MD; AllianceChicago
Alliance Site PI	Same as PI
Health Centers	Available to all Chicago CHCs in the AllianceChicago network
Description	AllianceChicago has been awarded funding through the Eugene Washington PCORI Engagement Awards program, a PCORI initiative, to support the implementation of the CHECS project in the AllianceChicago CHC Network. The CHECS project is part of a portfolio of projects that PCORI has funded to help develop a community of patients and other healthcare stakeholders who have the knowledge, skills and partnerships to participate in and advance patient-centered outcomes research and patient-centered comparative effectiveness research.
Objectives/ Goals/ Deliverables	**Year 1** 1. Provide access to an online training curriculum through the Clinical Director's Network (CDN) to the AllianceChicago Network. **Year 2** 1. Dynamic, live seminar-style training sessions will be disseminated to individuals that are selected to participate in year. 2. Mentorship workshops and in-person trainings to support the development of a research proposal.

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Chronic Disease and School Health (CDASH)

Time Frame	7/2016-11/2017
Funder	Illinois Department of Public Health
PI	Janae Price, MPH; Illinois Department of Public Health
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	TBD
Description	AllianceChicago is working with the Illinois Department of Public Health on a project to promote the adoption of food service guidelines and physical education and activity, participation in diabetes programs, reporting of blood pressure and A1C measures, and increase awareness of prediabetes and diabetes risk.
Objectives/ Goals/ Deliverables	1. Promote adoption of food service guidelines/nutritional standards. 2. Create supportive nutritional environments in schools. 3. Increase electronic health records (EHR) adoption and the use of health information technology to improve performance.

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Data Across Sectors for Health: Empowering Communities Through Shared Data and Information (DASH) – Chicago Lead Hazard Data Sharing

Time Frame	1/2016 -11/2017
Funder	Robert Wood Johnson Foundation
PI	Raed Mansour, MS; Chicago Department of Public Health
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Near North Health Service Corporation
Description	This project builds on prior work between the Chicago Department of Public Health (CDPH) and Chicago Public Schools (CPS), Chicago Department of Innovation and Technology (DoIT), and the University of Chicago's Center for Data Science and Public Policy (DSaPP). This initiative will connect information systems from four sectors to improve information sharing and decision making among each. Multi-sector information management and data sharing produces tremendous benefits as data held by disparate sectors can be centrally combined making record-level data more complete, timely and actionable. It is designed to impact individual client/patient needs while improving the health status of broader populations, and utilizes a use case of lead poisoning as the catalyst for additional cross-sector collaboration. AllianceChicago will provide actionable information to healthcare professionals working in vulnerable areas through electronic health records. We will serve as the healthcare entity utilizing external data to enhance activities at the point of care.
Objectives/ Goals/ Deliverables	1. To preemptively inspect a home for lead hazards and remediate it before a child is poisoned. 2. To test the effectiveness of the predictive model in finding homes with lead hazards.

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Electronic Health Record-based Medication Complete Communication (EMC2)

Time Frame	8/2015 – 5/2019
Funder	National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
PI	Mike Wolf, PhD; Northwestern University
Alliance Site PI	Fred Rachman, MD
Health Centers	Near North Health Service Corporation
Description	The Health Literacy & Learning Program (HeLP) at Northwestern University is partnering with AllianceChicago network CHCs on capitalizing on the integrated EHR infrastructure and pioneering new ways to simplify and improve the delivery of healthcare to patients. EMC2 aims to improve patients' understanding of the risks associated with high-risk prescriptions to ensure that patients are taking medications safely. EMC2 is a strategy that leverages the EHR and interactive voice response (IVR) to (1) prompt and guide provider counseling, (2) automate the delivery of medication guides at prescribing, (3) engage patients post-visit via IVR to confirm they are using prescription properly, and (4) activate the clinical team to help patients overcome barriers to safe medication use.
Objectives/ Goals/ Deliverables	1. Test the effectiveness of the EMC2 Strategy, compared to usual care, to improve: H1) patient understanding of risks, H2) patients' demonstrated safe use, H3) detection of ADEs 2. Assess whether the EMC2 Strategy can reduce disparities in understanding and demonstrated safe use by patient literacy level, English proficiency, and age compared to usual care. 3. Evaluate the effectiveness and fidelity of the EMC2 Strategy to promote provider counseling, deliver patient Rx information, monitor use, and inform providers of potential harms. 4. Explore patient, provider, and health system barriers to implementation and effectiveness. 5. Determine the cost of delivering the EMC2 strategy from a health system perspective.

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Examining Care Cascades to Understand and Improve HIV and Non-Communicable Chronic Disease Comorbidity Management

Time Frame	11/2017 – 10/2018
Funder	Third Coast Center for AIDS Research (CFAR)
PI	Lisa Hirschhorn, MD, MPH; Northwestern University
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Howard Brown Health
Description	Northwestern University is partnering with Howard Brown Health and AllianceChicago on an analysis of care cascades to help improve dual management of HIV and Diabetes Mellitus(DM). The work will include description of success rates along the relevant care continuum(s) for three groups and explore demographic factors associated with identified gaps. The project will also compare success rates along the HIV care continuum for PLWH with and out DM (viral suppression as primary outcome) and using a matched case control, success along the DM continuum for people with DM with and without HIV (primary outcomes HgbA1C and blood pressure control). We will also use multivariate modeling to explore the association of other patient and treatment factors with success for the HIV continuum and the DM continuum. The results will be shared with HBH to reflect on identified gaps and successes in the context of their current models for HIV and DM care. The work will culminate in a stakeholders meeting to identify opportunities for future grants to expand the populations studies and potential evidence-based interventions to adapt and test to improve HIV comorbidity management.
Objectives/ Goals/ Deliverables	1. Measure the prevalence of HIV, diabetes mellitus, and co-occurrences of HIV and DM in patients at Howard Brown Health; 2. Measure and compare the percent of patients along the steps of their respective care cascades for three populations; 3. Convene stakeholders to identify next steps towards the development of future research proposals for broader measurement of dual cascade success and adaptation and testing evidence-based interventions to improve identified gaps;

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Healthy Hearts in the Heartlands (H3) aka Midwest Small Practice Care Transformation Research Alliance (MSPCTRA)

Time Frame	5/2015 – 4/2018
Funder	Agency for Healthcare Research and Quality (AHRQ)
PI	Abel Kho, MD; Northwestern University
Alliance Site PI	Fred Rachman, MD
Health Centers	Heartland Health Outreach, Heartland Health Centers, Near North Health Service Corporation, Friend Family Health Center, Alivio Medical Center, Howard Brown Health
Description	H3 is a federally-funded research program that will work with small practice clinics in the Midwest to implement and evaluate quality improvement strategies for cardiovascular care. Small practices receive one year of hands-on coaching, tools, and strategies to provide point-of-care support for Million hearts cardiovascular measures – aspirin therapy, blood pressure control, cholesterol management and smoking cessation. Half of the practices will also receive support to engage in population health management.
Objectives/ Goals/ Deliverables	4. Strengthen prevention for heart disease and stroke by focusing on the ABCS – Aspirin, Blood pressure control, Cholesterol management and Smoking cessation; 5. Build or enhance its infrastructure to report and use quality data to improve care; 6. Generate new opportunities for providers to earn continuing medical education (CME) credits and maintain their board certifications; 7. Prepare to take advantage of fee-for-service reimbursement opportunities and quality-based incentive programs; and 8. Prepare for our healthcare system's rapid shift toward value-based reimbursement.

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Hepatitis C Community Alliance for Testing and Treatment in Chicago (HepCCATT)

Time Frame	9/2014 – 9/2018
Funder	Centers for Disease Control and Prevention (CDC)
PI	Daniel Johnson, MD; University of Chicago
Alliance Site PI	Fred Rachman, MD
Health Centers	Erie Family Health Center, Heartland Health Centers, Heartland Health Outreach, Howard Brown Health, Near North Health Service Corporation, The Night Ministry, PCC Wellness, TCA Health, Inc.
Description	The Extension for Community Healthcare Outcomes Chicago (ECHO-Chicago) program at the U of C Medicine received a grant from CDC to lead an unprecedented public health collaboration to reduce Hepatitis C (HCV) infections in Chicago. The grant will fund HepCCATT to build Chicago's capacity to test for and cure HCV infections. HepCCATT brings together leading academic medical centers, community health providers (Alliance), corporate partners, and advocacy groups in collaboration with IDPH and CDPH.
Objectives/ Goals/ Deliverables	1. Public education on hepatitis C risk factors and importance of testing 2. Expand primary care provider (PCP) capacity to treat, and cure HCV at community health centers 3. Robust surveillance to monitor population-level changes in HCV testing, treatment, and cure 4. Coordination among all stakeholders to improve access and reduce the cost of HCV care

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Illinois Precision Medicine Consortium (IPMC) – *All of Us*

Time Frame	11/2016 – 10/2021
Funder	National Institute of Health (NIH)
PI	Phillip Greenland, MD; Northwestern University
Alliance Site PI	Fred Rachman, MD
Health Centers	TBD
Description	This project involves a large, multi-Health Provider Organization (HPO) collaboration to engage, recruit, and retain a population-representative cohort of 150,000 patients and to collect, integrate, and share demographic, anthropomorphic, clinical, biospecimen, and other longitudinal data to inform new scientific discoveries and future subsequent research across the age spectrum.
Objectives/ Goals/ Deliverables	1. AllianceChicago network CHC site leaders will facilitate individual patient stakeholder engagement in refining the IPMC study design 2. Alliance leaders will collaborate on subcommittees to define key attributes of effective recruitment of low income and predominantly minority primary care patients; pragmatic data collection in CHC settings; and integration and sharing of electronic health provider organization data across other regional HPOs and with the NIH. 3. Collaborate with NU and other IPMC co-investigators to design and pre-test a series of novel patient engagement and recruitment procedures that have the potential for sustainable implementation in both FQHC and non-FQHC settings. 4. Co-develop, implement, and maintain Alliance-level data extraction and data-sharing processes that will enable the integration of Alliance-member CHC data with other regional HPO data sources.

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Improving Diagnosis of Hypertension in Children (IDHC)

Time Frame	12/2015 – 10/2017
Funder	Agency for Healthcare Research and Quality (AHRQ)
PI	Goutham Rao, MD; NorthShore University HealthSystem
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Erie Family Health Center
Description	This project, in collaboration with Northshore University HealthSystem, integrates provider feedback on diagnosis and management of pediatric blood pressure and uses this feedback to guide the development of Clinical Decision Support (CDS) to improve the diagnosis and management of elevated blood pressure in children. The overall purpose of the proposed research is to develop, implement, and evaluate the impact of a program in a large network of community-based practices which serve primarily minority children and families.
Objectives/ Goals/ Deliverables	The intervention includes education and/or training for clinicians and parents, as well as clinical decision support within an electronic health record system which facilitates diagnosis and makes recommendations for follow-up, evaluation, and management. The principal outcome is the change in the proportion of children whose hypertension is accurately diagnosed between the 15-month period prior to the intervention and the 15-month intervention period in each of the two groups.

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Improving Diabetes Risk Assessment and Screening in Minority-Predominant Community Health Center Patients

Time Frame	9/2016 – 8/2017
Funder	National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
PI	Matthew J. O'Brien, MD, MPH; Northwestern University
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Heartland Health Outreach, Erie Family Health Center, Near North Health Service Corporation, Howard Brown Health, Heartland Health Centers; The Night Ministry, TCA Health, Inc, Friend Family Health Center, and Angel Harvey thus far.
Description	This project proposes to analyze data from a large population of minority-predominant community health center patients to improve diabetes risk assessment and compare the effectiveness of diabetes screening strategies based on alternate risk assessments. The findings from this study will help optimize the performance of diabetes screening strategies to better identify high-risk individuals, especially racial and ethnic minorities, which may lead to improvements in both population health and health equity.
Objectives/ Goals/ Deliverables	The proposed study will use national AllianceChicago EHR data from 2006-2015 to achieve the following specific aims: Aim 1: Compare the performance of alternate screening criteria to predict clinically-detected dysglycemia using longitudinal EHR data from minority-predominant community health center patients Nationwide. Aim 2: Estimate and compare the costs and short-term cost-effectiveness of screening minority-predominant community health center patients using three different screening approaches: 1) the novel risk prediction criteria using variables from the EHR; 2) USPSTF criteria; and 3) ADA criteria.

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Northwestern University Clinical & Translational Sciences Institute

Time Frame	9/2016 – 8/2017
Funder	Northwestern University
PI	Nivedita Mohanty, MD; AllianceChicago
Alliance Site PI	Same as PI
Health Centers	N/A
Description	This project involves the development and piloting of a suite of resources to align clinical and translational research with clinical primary care practices and disseminate the findings of research to clinicians and patients in ways that advance the concept of a “learning health system” and better patient outcomes. The expectation is that this collaboration between Northwestern University’s Center for Community Health (CCH) and AllianceChicago will seed the development of new relationships and structures that will leverage greater funding through additional mechanisms, potentially resulting in new research initiatives.
Objectives/ Goals/ Deliverables	1. Align research with clinical practice priorities. 2. Disseminate Research using the EHRS and other channels 3. Engage stakeholders in the appropriateness of research opportunities 4. Facilitate Research Recruitment 5. Evaluation 6. Build Knowledge

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Promoting Health: Improving Patient Outcomes for Childhood Obesity through a Coordinated System of Care

Time Frame	1/2017 – 3/2018
Funder	Sprague, Telligen, Harmony
PI	Mary Elsner, JD; The Illinois Chapter of American Academy of Pediatrics
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Erie Family Health Center, Heartland Health Centers
Description	ICAAP, AllianceChicago, Lurie Children's Hospital, and various community-based organizations are working together on a project designed to support families of children who are overweight and obese. This project allows providers to identify children with a BMI >85% and assess readiness to change behaviors to promote health weight. Families are referred to the ICAAP Care Coordinator who facilitates referrals to community based programs and tracks participation.
Objectives/ Goals/ Deliverables	1. Assist pediatricians and other medical providers in the Chicagoland area to improve their care of obese and overweight children. 2. To implement effective prevention strategies with at risk patients and families.

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Reducing Tobacco Use Disparities Among Adults in Safety Net Community Health Centers (Choose to Change Study)

Time Frame	9/2015 – 8/2018
Funder	National Cancer Institute (NCI)
PI	Brian Hitsman, PhD; Northwestern University
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Near North Health Service Corporation
Description	As a part of the Chicago Cancer Health Equity Collaborative (Chicago CHEC), and in partnership with Northwestern University, University of Illinois Chicago, and Northeastern Illinois University, AllianceChicago is excited to be participating in a new grant from the National Cancer Institute which aims to foster meaningful cancer research, education, training, and outreach in Chicago's underserved communities. Specifically, AllianceChicago is collaborating on an effort to improve patients' health through an opportunity to quit smoking as a part of the Choose to Change program.
Objectives/ Goals/ Deliverables	With Near North Health Service Corporation as the pilot site, the goal of this research is to evaluate whether using the electronic health record (EHR) system to identify patients who smoke and reach out to them with information about treatment options helps them make a quit attempt. One part of Choose to Change involves sending patients a letter and text or voice messages designed to help motivate them to accept free stop smoking coaching and free nicotine replacement medication from the Illinois Tobacco Quitline. Patients are encouraged to choose their own stop smoking goal, which may include quitting completely or gradually cutting down as a first step to trying to quit. A second part of Choose to Change involves easily connecting patients to the Quitline and then providing feedback to Near North Health Service Corporation providers to support follow-up care.

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Third Coast Center for AIDS Research (TC CFAR)

Time Frame	6/2016 – 5/2017
Funder	National Institutes of Health (NIH)
PI	Richard D'Aquila, PhD; Northwestern University
Alliance Site PI	Timothy Long, MD
Health Centers	N/A
Description	TC FAR is collaborating with AllianceChicago, Northwestern University, University of Chicago, and Chicago Department of Public Health to harmonize and link data and plan for research and care improvement across all these institutions. TC CFAR is one of a national network of Centers for AIDS Research, the purpose of which is to synergistically enhance and coordinate high quality AIDS research projects. The emphasis is on collaboration between basic and clinical investigators to enhance translational research.
Objectives/ Goals/ Deliverables	1. AllianceChicago will support TC CFAR by contributing to the development of new systems to identify/refer eligible patients to research studies at the CFAR academic sites (Northwestern University and University of Chicago) from AllianceChicago network CHCs. 2. AllianceChicago will also develop strong HIV clinical outcomes research using EMR data to identify new funding opportunities via CFAR partnerships. 3. AllianceChicago will support the Scientific Working Group (SWG) and the Clinical Sciences Core by leveraging EMR-derived clinical data. 4. Lastly, AllianceChicago will work with the CFAR SWG to increase provide/patient education/engagement using EMR and clinical decision-making tools.

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Universal Medication Schedule (UMS) Portal

Time Frame	9/2015 – 5/2020
Funder	National Institute on Aging (NIA)
PI	Mike Wolf, PhD; Northwestern University
Alliance Site PI	Nivedita Mohanty, MD
Health Centers	Erie Family Health Center
Description	This project is an extension of a recent Merck project at Near North Health Service Corporation (Near North) and Erie Family Health Center (Erie). For this current, NIA-funded trial, we have listened to providers at Near North and Erie sites and will 1) improve how the above EHR medication tools function in clinic practice to mitigate any impact on workflow; 2) expand beyond diabetes and cardiovascular medications covered by the existing project to offer a more comprehensive primary care product. Most importantly, we also will test the effectiveness of two additional UMS tools that may greatly benefit patients: 1. SMS text reminders to support memory and promote adherence 2. Patient portal tools that aid in medication reconciliation, provide medication education, routinely assess patients' safe use and adherence to Rx regimens, and report back to providers via the EHR on their patients' medication taking behaviors.
Objectives/ Goals/ Deliverables	1. Compare the effectiveness of the UMS EHR tools, with or without SMS and/or Portal interventions. 2. Evaluate the 'fidelity' (reliability) of each strategy and explore patient, staff, physician, and health system factors influencing the delivery of the interventions, alone and in combination. 3. Assess the costs required to deliver each of the interventions from a health system perspective.