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# Building Primary Care Capacity for the Management of Complex Pediatric Asthma in Underserved Communities on the South Side of Chicago

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Capacity-building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Health Resources and Services Administration (HRSA)</td>
</tr>
<tr>
<td>PI</td>
<td>Daniel Johnson, MD; University of Chicago</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Centers, Near North Health Service Corporation, Friend Family Health Center, Heartland Health Centers</td>
</tr>
</tbody>
</table>

## Description
The Extension for Community Health Outcomes (ECHO) is an innovative program that builds primary care capacity and increases use of best practice protocols at community health centers through advanced training for PCPs in managing common chronic diseases. ECHO-Chicago, the longest-running urban ECHO program, uses high-grade videoconferencing technology to bring together disease specific specialty teams from the University of Chicago Medicine (UCM) with community-based PCPs to form knowledge networks guided by curriculum-driven, case-based, iterative training similar to “virtual rounds.” ECHO-Chicago will implement a new series focused on complex pediatric asthma and forge new collaborations with two other UCM programs – the Comer Children’s Asthma Center and the Pediatric Asthma Community Health Worker Program.

## Aims
1. Build capacity for the management of complex pediatric asthma among community-based PCPs
2. Improve the use of evidence-based asthma management practices among PCPs
3. Connect children with asthma on the South Side to PCPs trained in complex pediatric asthma management
## Alliance for Cancer Care

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Merck Foundation</td>
</tr>
<tr>
<td>PI</td>
<td>Melissa Simon, MD, MPH; Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Near North Health Service Corporation; Howard Brown Health Center</td>
</tr>
<tr>
<td>Description</td>
<td>The Alliance for Cancer Care project is 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.</td>
</tr>
</tbody>
</table>
| Aims               | 1. To create models and approaches that bolster more connected integration between primary care and cancer care.  
2. To build capacity, protocols & knowledge of guidelines necessary to deliver the required spectrum of care.  
3. To optimize 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. |
# Multi-state EHR-based Network for Disease Surveillance (MENDS)

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Legacy Community Health; Heartland Health Centers; Heartland Alliance Health; Friend Health; Erie Family Health Centers; Near North Health Service Corporation; North Country; North Central Nursing Clinics; Nursing Practice Corporation; Malama I Ke Ola Health Center; Hamakua-Kohala Health Centers; Settlement Health; Family Health New York</td>
</tr>
<tr>
<td>Description</td>
<td>MENDS is a pilot, EHR based, chronic disease surveillance system, led by the National Association of Chronic Disease Directors (NACDD) and funded by CDC Division for Heart Disease and Stroke Prevention. As technology advances, estimates of chronic disease prevalence and incidence will likely move away from surveys. Participation in MENDS can help in the development of a new national chronic disease surveillance system. It can also promote collaboration with local and statewide public health agencies by sharing common data and identifying public health problems that can be best addressed through joint public health and clinical interventions. MENDS can also pinpoint geographic hot spots of specific risk factors to better plan programs and evaluate their impact.</td>
</tr>
<tr>
<td>Aims</td>
<td>1. Visualize the prevalence of specific disease conditions and control of those conditions in your population; 2. Query the impact of chronic disease quality improvement efforts; 3. Compare participating clinical sites’ performance</td>
</tr>
</tbody>
</table>
**Preventing Tipping Points in High-Comorbidity Patients: A Lifeline from Health Coaches**

<table>
<thead>
<tr>
<th><strong>Project Type</strong></th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>Patient-Centered Outcomes Research Institute (PCORI)</td>
</tr>
<tr>
<td><strong>PI</strong></td>
<td>Jonathan Tobin, PhD; Clinical Directors Network (CDN)</td>
</tr>
<tr>
<td><strong>AllianceChicago PI</strong></td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td><strong>AllianceChicago Project Manager</strong></td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td><strong>Health Centers</strong></td>
<td>Erie Family Health Centers, Friend Family Health Center</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>The “Tipping Points” project studies how health coaches may affect the health and wellness of patients with multiple chronic diseases. The new health-coaching program will augment regular medical care, including positive affect interventions designed to help patients set their own life goals.</td>
</tr>
<tr>
<td><strong>Aims</strong></td>
<td>This pragmatic cluster randomized clinical trial (RCT) will evaluate the comparative effectiveness of two approaches to preventing destabilization (“tipping points”) that lead to unplanned hospitalization and increased disability. The RCT will compare outcomes of patients randomized to either a: 1. Patient Centered Medical Home (PCMH) as implemented by FQHCs (Usual Care); or 2. FQHC PCMH plus a Community Health Worker/Health Coach (CHW/HC) delivered intervention that employs a positive affect/self-affirmation to motivate patients to set life goals (Experimental).</td>
</tr>
</tbody>
</table>
# Diabetes

## Chicago Cares: Diabetes Prevention Project

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Clinical Content Development and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Northwestern University</td>
</tr>
<tr>
<td>PI</td>
<td>Matthew J. O’Brien, MD, MPH; Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Centers</td>
</tr>
</tbody>
</table>

**Description**

Customize already-existing Diabetes Prevention Project (DPP) clinical content in accordance with requested client updates, validate updates, and implement within Erie Family Health Center EMR; Train Erie Family Health Center staff on updated content.

1. To develop DiRECT, a brief risk communication intervention about type 2 diabetes (T2D) prevention delivered by medical assistants (MA) to adult patients with prediabetes prior to their routinely scheduled primary care office visits.
2. To evaluate the effects of the DiRECT intervention on perceived T2D risk, knowledge, and intentions to adopt ILI (intensive lifestyle intervention) and/or metformin among adult patients with prediabetes, in a pretest-posttest trial.
3. To estimate the preliminary effects of DiRECT vs. usual care on the following 3-month outcomes: 1) initiation of ILI and/or metformin (primary); 2) adherence to these treatments; and 3) weight loss, in a randomized pragmatic trial of 80 patients with prediabetes.
**Novel Clinical Decision Support to Promote Diabetes Prevention in Chicagoland Community Health Centers**

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Clinical Content Development and Data; Key Informant Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
</tr>
<tr>
<td>PI</td>
<td>Matthew J. O’Brien, MD, MPH; Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Centers</td>
</tr>
</tbody>
</table>

**Description**

The Prevent Diabetes Mellitus CDS (PreDM CDS) will address gaps in implementing evidence-based treatments for Type 2 diabetes (T2D) prevention for community health center patients with prediabetes and overweight/obesity. Guided by the “5 Rights” framework, this CDS will automatically generate the following components that are offered to eligible patients by the primary care team: 1) a decision aid about T2D prevention developed by our group; 2) an EHR referral to community-based intensive lifestyle intervention (ILI) programs that meet USPSTF requirements and are located in patients’ zip code; and 3) a prompt for clinicians to consider prescribing metformin. Clinicians will receive monthly feedback about their use of the PreDM CDS through an existing dashboard.

**Aims**

1. To design the PreDM CDS, which provides prediabetic patients with a decision aid about T2D prevention and prompts the primary care team to offer ILI and metformin as recommended by clinical practice guidelines.
2. To test the effectiveness of the PreDM CDS at inducing weight loss and improving other cardiometabolic markers among prediabetic adults using a pragmatic cluster randomized trial of 6 large community health center sites located throughout Chicago.
3. To examine the reach, adoption, implementation, maintenance, and costs of the PreDM CDS, providing data that will support its scalability and sustainability.
### Improving Health Outcomes and Satisfaction of Sexual and Gender Minority Patients Through Cultural Competence Training for Non-Clinical Staff and Clinical Providers in Federally Qualified Community Health Centers

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Provider Education</th>
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<tbody>
<tr>
<td>Funder</td>
<td>Patient Centered Outcomes Research Institute (PCORI)</td>
</tr>
<tr>
<td>PI</td>
<td>Kenneth Mayer, MD; Fenway Health</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Heartland Alliance Health, Howard Brown Health, Near North Health Service Corporation, North Country Healthcare, Nursing Practice Corporation, Legacy Community Health</td>
</tr>
<tr>
<td>Description</td>
<td>The primary goal of this project is to evaluate the impact of enhanced provider and clinical staff training to address the health disparities of Sexual Gender Minority (SGM) CHC patients to ultimately improve their health outcomes. Based on national probability studies, at least 3.5% of their patients are SGM, but few CHCs have systematically collected data about SOGI and only a minority have undertaken intensive staff training to optimize their provision of care for SGM patients. This project is intended to learn how to best train CHCs in the collection of data that will enable them to identify and provide optimal care for their SGM patients, and to evaluate whether enhanced education regarding LGBT health disparities and the optimal provision of culturally-competent care will result in improved health outcomes as assessed through evaluation of appropriate health screenings and clinical actions documented in EHRs, and through the assessment of patient satisfaction.</td>
</tr>
</tbody>
</table>
| Aims             | 1. To conduct key informant interviews of FQHC staff and consumers  
2. To refine an optimized training program for non-clinical staff, clinicians and administrators  
3. To compare the effectiveness of the optimized LGBT health training program to usual practice |
Universal Medication Schedule (UMS) Portal

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention and Data</th>
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<tbody>
<tr>
<td>Funder</td>
<td>National Institute on Aging (NIA)</td>
</tr>
<tr>
<td>PI</td>
<td>Mike Wolf, PhD; Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Centers</td>
</tr>
</tbody>
</table>

Description
This project is an extension of a recent Merck project at Near North Health Service Corporation (Near North) and Erie Family Health Centers (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.

Aims
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.
<table>
<thead>
<tr>
<th><strong>Project Type</strong></th>
<th>Clinical Decision Support</th>
</tr>
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<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>Centers for Disease Control and Prevention (CDC)</td>
</tr>
<tr>
<td><strong>PI</strong></td>
<td>Blackford Middleton, MD; Apervita</td>
</tr>
<tr>
<td><strong>AllianceChicago PI</strong></td>
<td>Andrew Hamilton, RN, BSN, MS/ Nivedita Mohanty, MD</td>
</tr>
<tr>
<td><strong>AllianceChicago Project Manager</strong></td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td><strong>Health Centers</strong></td>
<td>Near North Health Service Corporation</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Apervita is working in collaboration with the CDC and AllianceChicago to demonstrate and evaluate clinical decision support (CDS) derived from the CDC 2015 Sexually Transmitted Diseases guideline for gonorrhea care in the GE Office Centricity EHR in a laboratory evaluation setting. This evaluation will assess providing CDS services to clinicians through the GE Office Centricity EHR in a laboratory evaluation setting to help ensure patients receive care that is consistent with the most current and authoritative treatment guidelines</td>
</tr>
</tbody>
</table>
| **Aims**            | 1. Develop an implementation plan for the Apervita eCDS services that addresses CDS content and workflow implementation for gonorrhea treatment and management decision support.  
                      2. Apervita will implement the Gonorrhea CDS using the EHR platform in AllianceChicago network. |
## The Patient and Community-centered Research Infrastructure Development and Education Project (PC-RIDE)

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Data and information sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Third Coast Center for Aids Research in Chicago</td>
</tr>
<tr>
<td>PI</td>
<td>Jessica Ridgway, MD, MS, University of Chicago</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Jodi Simon, DrPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Jena Wallander, MPH, BSN, RN</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Howard Brown Health; Erie Family Health Centers; Near North Health Service Corporation; Heartland Alliance Health; Heartland Health Centers; Friend Health</td>
</tr>
<tr>
<td>Description</td>
<td>The Patient and Community-centered Research Infrastructure Development project will leverage AllianceChicago’s health information technology assets and CHC partnerships across Chicago to achieve three aims for the Center For Aids Research planning grant:</td>
</tr>
<tr>
<td>Aims</td>
<td>1. Develop a data infrastructure for advancing research on PLWH across different CHCs including defining necessary clinical and social determinant variables to conduct analyses.</td>
</tr>
<tr>
<td></td>
<td>2. Develop a data infrastructure for advancing research on patients eligible for Pre-exposure prophylaxis (PrEP). This work will include defining an algorithm to identify eligible candidates as well as defining the clinical and social determinant variables for analyses.</td>
</tr>
<tr>
<td></td>
<td>3. Convene and educate CHC stakeholders and academic researchers on the data infrastructure for the purpose of leveraging the infrastructure to submit collaborative proposals for federal research funding.</td>
</tr>
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</table>
### Third Coast Center for AIDS Research (TC CFAR)

<table>
<thead>
<tr>
<th><strong>Project Type</strong></th>
<th>Data and information sharing</th>
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</thead>
<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>National Institutes of Health (NIH)</td>
</tr>
<tr>
<td><strong>PI</strong></td>
<td>Richard D’Aquila, PhD; Northwestern University</td>
</tr>
<tr>
<td><strong>AllianceChicago PI</strong></td>
<td>Timothy Long, MD/Lisa Masinter, MD, MS, MPH</td>
</tr>
<tr>
<td><strong>AllianceChicago Project Manager</strong></td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td><strong>Health Centers</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Aims** | 4. 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.  
5. AllianceChicago will also develop strong HIV clinical outcomes research using EMR data to identify new funding opportunities via CFAR partnerships.  
6. AllianceChicago will support the Scientific Working Group (SWG) and the Clinical Sciences Core by leveraging EMR-derived clinical data.  
7. Lastly, AllianceChicago will work with the CFAR SWG to increase provide/patient education/engagement using EMR and clinical decision-making tools. |
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.

### Aims

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
# Chicago Area Patient-Centered Outcomes Research Network (CAPriCORN)

<table>
<thead>
<tr>
<th><strong>Project Type</strong></th>
<th>Clinical Data Research Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>People Centered Research Foundation (PCRF)</td>
</tr>
<tr>
<td><strong>PI</strong></td>
<td>Abel Kho, MD; Northwestern University</td>
</tr>
<tr>
<td><strong>AllianceChicago PI</strong></td>
<td>Fred Rachman, MD</td>
</tr>
<tr>
<td><strong>Project Manager</strong></td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>CAPriCORN seeks 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.</td>
</tr>
</tbody>
</table>
| **Aims**        | 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) |
<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention</th>
</tr>
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<tbody>
<tr>
<td>Funder</td>
<td>National Association of Community Health Centers</td>
</tr>
<tr>
<td>PI</td>
<td>Ron Yee, MD; NACHC</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Family Christian Health Center, TCA</td>
</tr>
<tr>
<td>Description</td>
<td>The Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion, NACHC, and the Healthy Weight Partnership (HWP) will collaboratively work together to design an implementation model using clinical evidence (results from CORD and MEND) as well as health center learning models based on implementation science with quality improvement infrastructure. Four primary care associations (PCAs) and approximately 16 health centers (4 engaged by each PCA) were selected to implement the evidence-based program, the MEND 7-13 Program. To address barriers of competition, care fragmentation, and limited resources to develop, test, and implement strategies to improve care for diverse populations and reduce health disparities.</td>
</tr>
</tbody>
</table>
| Aims                             | 1. Implement the MEND curriculum in participating health centers.  
2. Build capacity of families to make healthier nutrition and fitness choices.  
3. Decrease Body Mass Index (BMI) and waist circumference in participating children.  
4. Serve as a resource for providers in to help support patients who are obese. |
# Chicago Collaborative for Maternal Health

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Quality Improvement and Community Engagement</th>
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<tbody>
<tr>
<td>Funder</td>
<td>Merck for Mothers</td>
</tr>
<tr>
<td>PI</td>
<td>Lisa Masinter, MD, MPH</td>
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<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
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<tr>
<td>AllianceChicago</td>
<td>Jena Wallander, MPH, BSN, RN</td>
</tr>
<tr>
<td>Project Manager</td>
<td></td>
</tr>
<tr>
<td>Health Partners</td>
<td>Erie Family Health Center, Howard Brown Health, Near North Health Service Corporation, Heartland Health Centers, ACCESS Community Health Network, Mile Square Health, Esperanza Health Center, PCC Wellness, John H Stroger Hospital of Cook County, Norwegian American Hospital</td>
</tr>
<tr>
<td>Description</td>
<td>The Chicago Collaborative for Maternal Health (CCMH) seeks to improve maternal health outcomes in Chicago. It is a Safer Childbirth Cities Project funded by Merck for Mothers. AllianceChicago is partnering with EverThrive Illinois, the Illinois Perinatal Quality Collaboration, the University of Illinois at Chicago School of Public Health, the Chicago Department of Public Health, the Illinois Department of Public Health, and additional community partners and CHCs in this effort.</td>
</tr>
</tbody>
</table>
| Aims                 | 1. Establish a quality improvement (QI) collaborative to improve health care quality for women receiving care in the ambulatory setting  
                         2. Community engagement campaign to improve awareness and empower women and families  
                         3. Policy initiative informed by the findings of the initiative. |
## Data Across Sectors for Health

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Clinical Content and Data</th>
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<tbody>
<tr>
<td>Funder</td>
<td>Chicago Department of Public Health</td>
</tr>
<tr>
<td>PI</td>
<td>Raed Mansour, MD, Chicago Department of Public Health</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Jena Wallander, MPH, BSN, RN</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Center, Near North Health Service Corporation</td>
</tr>
<tr>
<td>Description</td>
<td>This project harnesses data science and predictive analytics to create a real-time, actionable system to predict and remediate lead poisoning hazards before children are poisoned, preventing lifelong detrimental health and development consequences.</td>
</tr>
</tbody>
</table>
| Aims | 1. Connect disparate information systems from the public and healthcare sectors in Chicago to improve information sharing of regional lead prevalence data.  
2. Develop a Predictive Model with the capability to predict risk of lead poisoning based on home geography, patient age, and if available, previous lead results from the patient.  
3. Design a Health Information Exchange (HIE) interface from the Electronic Health Record System (EHRS) that connects to the DoIT system to return a “Risk Score” to pediatric and obstetric providers in real-time.  
4. Design Clinical Decision Support (CDS) that guides providers on existing gaps in lead screening for the patient, provides lead abatement education for families, and identifies the need for Visual Home Inspections for Lead. |
Intervention to Reduce Early (Peanut) Allergy in Children (iREACH)

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Clinical Decision Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>PI</td>
<td>Ruchi Gupta, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Erie Family Health Center, Near North Health Service Corporation</td>
</tr>
</tbody>
</table>

Description

AllianceChicago has partnered with Dr. Ruchi Gupta on the iREACH study. iREACH aims to reduce peanut allergy risk through a clinical decision support (CDS) tool incorporated into participating health centers’ electronic health record. The CDS iREACH tool, developed and tested by pediatricians, is designed to support providers in the following Pediatric Peanut Allergy guideline-recommended practices: 1) identify infants at high-risk for peanut allergy based on the presence of severe eczema and/or egg allergy, 2) order peanut-specific (s)IgE testing or allergist referrals for infants at high-risk for peanut allergy, 3) assess level of risk based upon peanut (s)IgE test results, if applicable, and 4) counsel parents of infants on introduction of peanut products.

Aims

1. Describe allergist adherence to the PPA guidelines
2. Describe parent adherence to the PPA guidelines, among parents from the intervention arm
3. Report barriers/facilitators for PPA guideline adherence among providers caring for pediatric patients, allergists, and parents
4. Measure rates of allergic reactions related to the introduction of peanut-containing foods in a subset of parents from the intervention arm
5. Measure the parent-reported and provider-documented incidence rates of PA, other food allergies, and other related atopic conditions at age 2.5
# The LINCC Trial: Linking Inter-specialty Newborn and Contraception Care: A Novel Approach to Postpartum Contraception Provision at the Well-Baby Visit

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>PI</td>
<td>Sadia Haider, MD; Rachel Caskey, MD</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Settlement Health, Malama I Ke Ola Health Center, Heartland Health Centers</td>
</tr>
<tr>
<td>Description</td>
<td>The LINCC Trial is a co-scheduling intervention that links well-baby visits with postpartum contraceptive care in order to reduce rates of short interval pregnancy</td>
</tr>
</tbody>
</table>
| Aims               | 1. Develop a comprehensive plan for implementing the infrastructure change needed to link postpartum contraception care with newborn care in CHCs  
                      2. Implement linked PP contraception and newborn care provision in 10 CHCs and evaluate the effect of linking care on PP contraception uptake and rates of short IPI  
                      3. Assess implementation post-intervention and report on key issues related to successful implementation |
### The OPTIMIZE Study: Optimizing Patient Navigation for Perinatal Care

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>PI</td>
<td>Melissa Simon, MD, Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Friend Health, Near North Health Service Corporation</td>
</tr>
<tr>
<td>Description</td>
<td>AllianceChicago is working with Dr. Melissa Simon from Northwestern University on the OPTIMIZE study. OPTIMIZE aims to address inequity perinatal healthcare, particularly for African American women. The OPTIMIZE checklist is a strategy to facilitate coordination and integration of efforts to improve perinatal care for AA women.</td>
</tr>
<tr>
<td>Aims</td>
<td>1. Develop the OPTIMIZE checklist with interviews and/or focus groups with AllianceChicago CHCs staff and patients</td>
</tr>
<tr>
<td></td>
<td>2. Conduct pragmatic, randomized trials in 4 CHCs to evaluate the effectiveness and implementation of the OPTIMIZE checklist strategy</td>
</tr>
<tr>
<td></td>
<td>3. Conduct process evaluation, including conducting organizational surveys and interviews with clinic staff and patients.</td>
</tr>
</tbody>
</table>
Reducing Disparities in Postpartum Care Utilization: Development of a Clinical Risk Assessment Tool

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Association of Women’s Health, Obstetric, and Neonatal Nurses</td>
</tr>
<tr>
<td>PI</td>
<td>Sandi Tenfelde, PhD, RN, APRN</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago Project Manager</td>
<td>Jena Wallander, MPH, BSN, RN</td>
</tr>
<tr>
<td>Description</td>
<td>The long-term goal is to develop an effective evidenced-based intervention to improve postpartum care for low-income women tailored to the community’s needs. Federally Qualified Health Centers (FQHCs) are community-based facilities in underserved areas, and AllianceChicago is an organization that consolidates the health information technology, research, and education for many of the FQHCs of Chicago. To meet this objective, our short-term goal is to conduct a secondary data analysis using AllianceChicago FQHC electronic health records to address the following aims:</td>
</tr>
<tr>
<td>Aims</td>
<td>1. Describe the risk factors of low-income women who do not return for postpartum visits as compared to women who do return for care. 2. Create and validate a point-based risk assessment scoring system to identify postpartum non-attendance that is easy to use for clinicians and researchers.</td>
</tr>
<tr>
<td>Project Type</td>
<td>Outpatient Surveillance Network</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Funder</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>PI</td>
<td>Robert Tanz, MD, Ann &amp; Robert H. Lurie Children's Hospital of Chicago</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD, MPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Infant Welfare Society</td>
</tr>
</tbody>
</table>

**Description**

This project will develop an outpatient surveillance network in 5 geographically distinct areas. Four of the areas will be geographically in proximity to existing ABCs locations and the fifth area, in Chicago, will combine outpatient pharyngeal collection (pediatric emergency department and general pediatric clinics) and collection of group a streptococci (GAS) from invasive infections treated at our pediatric hospital (Lurie Children’s Hospital, LCH) and our affiliated adult hospital (Northwestern Memorial Hospital, NMH). This approach would give us the ability to collect data across the spectrum of GAS disease in 5 circumscribed geographic areas.

**Aims**

1. Identify relationships between GAS isolated from patients in communities
2. Advance understanding of the epidemiology of GAS pharyngeal and invasive infections, post-streptococcal sequelae, and development of GAS vaccines
Testing the implementation of EHR-based population health tools to manage childhood hypertension (OpTIMISe)

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Clinical Decision Support and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>PI</td>
<td>JD Smith, Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Nivedita Mohanty, MD, MPH</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>TBD</td>
</tr>
<tr>
<td>Description</td>
<td>The centerpiece of this study is an electronic health record (EHR)-integrated population health management tool; prior research indicates that additional implementation strategies will be needed to institute practice- and provider-level adoption of this tool. These strategies will be identified by operations and clinical leaders in AllianceChicago, a network of community health centers that share a common infrastructure for health information technology, research, quality improvement, and practice transformation.</td>
</tr>
<tr>
<td>Aims</td>
<td>The purpose of this project is to identify effective and feasible implementation strategies to increase adoption and adherence to clinical practice guidelines for youth hypertension (HTN) management and understand the contextual factors that facilitate or act as barriers.</td>
</tr>
</tbody>
</table>
# The Implementation of Quality MEtricS Affects Visit Efficiency (TIMESAVE)

<table>
<thead>
<tr>
<th><strong>Project Type</strong></th>
<th>Observational Study and Secondary Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>American Medical Association</td>
</tr>
<tr>
<td><strong>PI</strong></td>
<td>Jeff Panzer, MD; Jodi Simon, DrPH</td>
</tr>
<tr>
<td><strong>AllianceChicago PI</strong></td>
<td>Jeff Panzer, MD; Jodi Simon, DrPH</td>
</tr>
<tr>
<td><strong>Project Manager</strong></td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td><strong>Health Centers</strong></td>
<td>Near North Health Service Corporation, Erie Family Health Center, Heartland Health Centers, Heartland Alliance Health, Night Ministry, Hill Country, Nursing Practice Corporation, Hamakua-Koloha Health Center, Malama I Ke Ola Health Center, Settlement Health, InConcert Care, North Central Nursing Clinics, Family Health of New York, Legacy Community Health Center, HealthFirst BlueGrass, Tri-State Community Health Center, Archer Family Health Care</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>The goal of this project is to <strong>explore the utilization of intake screening questions tied to performance metrics to assess workflow across community health centers (CHCs)</strong>, the scope of documentation of screening questions by workflow patterns, and the impact on efficiency. The findings will generate generalizable knowledge for community health center settings as well as to inform the broader primary care community.</td>
</tr>
</tbody>
</table>
| **Aim**          | 1. Describe implementation and utilization of screening questions tied to PMs in the AllianceChicago network of CHCs  
                     2. Assess efficacy of screening questions |

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

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Health Center Engagement and Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>PI</td>
<td>Phillip Greenland, MD, Northwestern University</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Fred Rachman, MD</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>TBD</td>
</tr>
<tr>
<td>Description</td>
<td>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</td>
</tr>
</tbody>
</table>
| Aims                  | 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 among 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. |
**Intervention in Small Primary care practices to Implement Reduction in unhealthy alcohol use (INSPIRE)**

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Quality Improvement and Capacity-Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
</tr>
<tr>
<td>PI</td>
<td>Abel Kho, MD/Theresa Walunas PhD</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Jodi Simon, DrPH</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>TBD</td>
</tr>
<tr>
<td>Health Centers</td>
<td>TBD</td>
</tr>
<tr>
<td>Description</td>
<td>Unhealthy alcohol use affects 38 million adults in the United States and is a leading cause of preventable mortality and a risk factor for an array of economic, social and health problems that has an estimated annual economic impact of $249 billion. This multi-disciplinary collaboration will use evidence-based quality improvement strategies to improve capacity of small primary care practices in IL and WI to implement Patient-Centered Outcomes Research (PCOR) evidence into the delivery of care for the unhealthy alcohol use.</td>
</tr>
<tr>
<td>Aims</td>
<td>In year 1, site will help engage practices within Alliance network to participate in the project and will work with NU to tailor the project plan to align with site’s existing initiatives to curtail unhealthy alcohol use. Site will also provide technology support for the EHR-based workflow. In year 2, site will provide EHR-based data to support evaluation of the project. In Year 3, site will participate in the decision making around evaluation and analysis of the data.</td>
</tr>
</tbody>
</table>
# Integration of a Bidirectional Electronic referral to the Illinois Tobacco Quitline

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Chicago Department of Public Health</td>
</tr>
<tr>
<td>PI</td>
<td>Jodi Simon, DrPH</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Jodi Simon, DrPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Elizabeth Adetoro, MPH</td>
</tr>
<tr>
<td>Health Centers</td>
<td>Near North Health Service Corporation, Howard Brown Health, Heartland Alliance Health</td>
</tr>
<tr>
<td>Description</td>
<td>AllianceChicago proposes the implementation and evaluation of a bidirectional eReferral tool to the Illinois Tobacco Quitline (ITQL) at three FQHCs in Chicago. The eReferral system will target all smokers who have a primary care visit during the grant period who are deemed by the provider to be ready to make a quit attempt. The process for making an eReferral will be integrated into the standard primary care visit workflow.</td>
</tr>
</tbody>
</table>
| Aims          | 1. Implement a bidirectional interface with ITQL and the EMR.  
2. Increase provider referrals to ITQL for patients determined to be ready to quit.  
3. Create a learning collaborative for health centers to learn from each other on best practices. |
Substance Use

Patients’ and Caregivers’ Understanding of the Serious Risks of Opioid Analgesics and How to Use These Products Safely: A Patient/Caregiver Survey (ER/LA)

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Patient Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder</td>
<td>Syneos Health</td>
</tr>
<tr>
<td>PI</td>
<td>Jonathan Tobin, PhD; Clinical Directors Network</td>
</tr>
<tr>
<td>AllianceChicago PI</td>
<td>Lisa Masinter, MD</td>
</tr>
<tr>
<td>AllianceChicago</td>
<td>Roxane Padilla, MPH</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Hill Country, North Country, Purdue</td>
</tr>
<tr>
<td>Description</td>
<td>Extended release (ER) and long-acting (LA) opioid analgesics are approved for the management of chronic moderate-to-severe pain in the United States (US). The Food and Drug Administration (FDA) approved a Risk Evaluation and Mitigation Strategy (REMS) for ER/LA opioid medications in 2012. The purpose of this study is to assess patient knowledge of the safe use of these products following implementation of the REMS and to determine possible effects of the REMS, including impact on access to medication.</td>
</tr>
</tbody>
</table>

Aims

1. To determine whether patients received the Medication Guide and/or Patient Counseling Document (PCD) and from whom;
2. To determine whether patients read the Medication Guide and/or PCD;
3. To assess level of patients’ knowledge related to ER/LA opioid analgesics