Addressing diabetes disparities on the South Side of Chicago:
Combining community strengths with health system innovation

Michael M. Davis Lecture Series
Center for Health Administration Studies

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Section of General Internal Medicine
Chicago Center for Diabetes Translation Research
Center for the Study of Race, Politics and Culture
South Side of Chicago

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

• Strengths
  – Historical social, political and cultural traditions
  – Community resources and institutions
  – Healthcare institutions
Diabetes Health Disparities

• African-Americans have worse diabetes health indicators
  ▪ Higher incidence and prevalence of disease
  ▪ Worse control of diabetes, lipids, blood pressure
  ▪ 2-4 times the rate of complications (retinopathy, ESRD, amputations)

• South Side of Chicago
  ▪ 19% estimated prevalence
  ▪ 5x rate of LE amputation
Chicago community areas by the racial-ethnic group that accounts for a majority of residents, by 2010 U.S. Census counts

Racial-ethnic majority
- No majority
- Hispanic or Latino
- Non-Hispanic Asian
- Non-Hispanic Black
- Non-Hispanic White
- Accounts for >95% of residents

According to the 2010 census, Chicago has 2.7 million residents. 37% are non-Hispanic black, 32% are non-Hispanic white, 25% are Hispanic or Latino, and 5% are non-Hispanic Asian.

Created by Chicago Dept. of Public Health Epidemiology and Public Health Informatics
Average annual adjusted diabetes-related mortality rate by Chicago community area, 2004 - 2008

- Per 100,000
  - Light blue: 26 - 59
  - Light blue (darker): 60 - 79
  - Medium blue: 80 - 99
  - Dark blue: 100 - 122

Nationally, 7.3 diabetes-related deaths per 100,000 occurred in 2007. The Healthy People 2020 target is 6.5.
Imputed diabetes-with-complications hospitalizations per 10,000 residents (age-adjusted) by Chicago community area, 2010

Community Areas
1. Rogers Park
2. West Ridge
3. Uptown
4. Lincoln Square
5. North Center
6. Lake View
7. Lincoln Park
8. Near North Side
9. Edgewater
10. Norwood Park
11. Jefferson Park
12. Forest Glen
13. North Park
14. Albany Park
15. Cottage Grove
16. Chatham
17. Archer Heights
18. Brighton Park
19. Cragin
20. Cermak
21. Pond Avenue
22. Logan Square
23. Humboldt Park
24. Ashland
25. Austin
26. West Garfield Park
27. East Garfield Park
28. Near West Side
29. North Lawndale
30. South Lawndale
31. Lower West Side
32. Loop
33. Near South Side
34. Armour Square
35. Douglas
36. Oakwood
37. Pulaski
38. Grand Boulevard
39. Kenwood
40. Washington Park
41. Hyde Park
42. Woodlawn
43. South Shore
44. Chatham
45. Avalon Park
46. South Chicago
47. Balmoral
48. Calumet Heights
49. Roseland
50. Pullman
51. South Englewood
52. East Side
53. West Pullman
54. Hegewisch
55. Garfield Ridge

Discharge per 10,000 (Age-adjusted)
- 6 - 17
- 18 - 29
- 30 - 41
- 42 - 53

Created by Chicago Dept. of Public Health Epidemiology and Public Health Informatics
Health Care Interventions to Reduce Diabetes Health Disparities

- Patient interventions (e.g. community health workers)
- Provider interventions (e.g. practice guidelines)
- Support staff interventions (e.g. RN case manager)
- Health systems interventions (e.g. diabetes registries)
- Few multi-target interventions with community partnerships
- No existing literature on interventions that target the patient/provider relationship

Improving Diabetes Care and Outcomes on Chicago’s South Side

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

• **Short-term goals:**
  – Improve access to care
  – Improve quality of care
  – Improve clinical outcomes

• **Long-term goals:**
  – Strengthen partnerships among HCs, CBOs and University of Chicago
  – Empower communities to address diabetes
  – Be sustainable
6 Participating Health Centers

- ACCESS Booker Family Health Center
- ACCESS Grand Boulevard Health Center
- Chicago Family Health Center
- Friend Family Health Center
- University of Chicago Kovler Diabetes Center
- University of Chicago Primary Care Group
Conceptual Model

- Community Partnerships
- Quality Improvement
- Patient Activation
- Provider Training

The Chronic Care Model

Community

Health Systems

Patient

Practice Team

Productive Interactions
Clinic Redesign

Each of our six clinic sites is implementing team-designed quality improvement (QI) projects to improve care for diabetes patients. QI projects follow the Model for Improvement plan-do-study-act methodology and are supported by experts from the field.

Each clinic has organized a diverse team of quality improvement champions. Champions represent staff from all areas of the clinic: check-in staff, referral coordinators, medical assistants, providers, and administration. Teams meet frequently to look at data, plan and implement projects, and track changes over time. Teams have access to a coach who can help answer questions, provide evidence-based examples and models, and assist with data collection and analysis.

Quarterly, all teams come together in Learning Sessions to share progress, troubleshoot barriers, and provide peer support. Each meeting has a theme relevant to the stage of implementation or common challenges/opportunities across sites.

Beth Littlejohn, MD is one of the provider champions for this project at the Kovler Diabetes Center. She helps keep the project’s work on track and brings enthusiasm to the team. The quarterly meetings are her favorite part of the work: she finds them “thought-provoking and inspiring.” “I think the concept of the Merck project is novel and brilliant,” says Beth, “and could serve as a model for delivery of care in other parts of the country and for other disease states.” Beth is Assistant Professor of Pediatrics at the University of Chicago and Associate Director of the Kovler Diabetes Center.

Related Content

These organizations are leaders in the field of quality improvement and health disparities. They guide much of the work that we do.

- Institute for Healthcare Improvement
- Improving Chronic Illness Care
- New Health Partnerships
Quality Improvement

• QI teams/collaborative
• One-on-one coaching
• Quarterly mtgs
• Organizational process evaluation/improvement
• PDSA cycles
Quality Improvement

• **Nurse care management**
  - UC Primary Care
  - Diabetes education, insulin initiation/titration, care management
  - Evidence:
    - 100% compliance w/ ADA standards (HbA1c, lipids, foot exam, kidney tests) vs. <50% in controls
    - -2.0 HbA1c at 6 mo (-3.5 HbA1c w/in group Δ)
    - 5x increased odds of retinopathy culturally-tailored case mgmt (RN + dietician)
Quality Improvement

• Diabetes group visits
  – Shared medical appts (SMA)
  – 2 FQHCs
  – Diabetes education, medication titration/clinical care, support group
  – Improved patient/provider satisfaction
  – Some evidence re: reduced costs, hospitalizations and improved health outcomes (lower blood pressure)
Quality Improvement

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

Quality Improvement

Patient Activation

Provider Training

The Chronic Care Model

Community

Health Systems

Patient

Practice Team

Productive Interactions
Provider Workshops

We work with healthcare providers to troubleshoot the challenges of communicating with their patients, recognize cultural stereotypes on which they may unknowingly rely, and effectively motivate patients towards health behavior change.

Our course objectives are to:

1) Identify and practice core communication skills for effective clinician-patient interactions;

2) Understand stages of behavior change (precontemplation, contemplation, preparation, action, maintenance) and different change processes; Practice assessing stage of change and tailoring interventions to different stages;

3) Practice incorporating motivational interviewing techniques (engage, empathize, educate, enlist) into patient encounters to optimize diabetes self-care;

4) Enhance provider sensitivity to patients’ cultural preferences to optimize clinician-patient interactions with diverse patient populations.

Rob Sargis, MD is a provider at the Kovler Diabetes Center. He sees himself as an advocate for his patients with diabetes and is dedicated to making diabetes a public health priority. Rob got involved in this project hoping that he could contribute to a plan to stem the tide of diabetes. "By far, my favorite part of this project is working with similarly-minded individuals who are committed to improving the care of diabetes in our community. The tremendous threat of diabetes to societal health is daunting, but working with such bright and talented people gives me hope that we can turn the tide against this terrible disease." Rob is Instructor of Medicine at the University of Chicago.

Feedback from our Workshops

"I very much enjoyed it and found it eye opening"

"Important, interesting, and needed topic"

"LOVED LOVED LOVED this lecture. Lots of new terminology, data, inspiring."

"Great series!"
Provider Intervention

- Provider communication training
  - Cultural competency
  - Behavioral change
  - Motivational Interviewing
  - Patient/provider communication and Shared Decision-Making

- Continuing medical education (CME)
  - Updates on management of diabetes, hypertension, hyperlipidemia, etc.
Patient Empowerment

Our patient empowerment program is an intensive, ten-week series of classes at our partner clinics. The program combines culturally-tailored, evidence-based diabetes education with skills training in communication and shared decision-making, a process whereby patients are equal partners in determining their treatment plans.

The goals of our patient classes are to:

1. Increase patient knowledge of diabetes;
2. Help patients acquire necessary skills in diabetes management;
3. Support patients as they try to live healthier lives with diabetes, both in the classroom and via community resources;
4. Empower patients to take a more active role with their physician in making decisions about their health care, by effectively communicating their treatment preferences and addressing barriers to shared decision-making.

Sheila Harmon, RN CDE was a key contributor to developing the Diabetes Empowerment Program. She loves seeing patients’ excitement when they make lifestyle changes and see results. “This Empowerment Curriculum ties in with what I believe,” says Sheila. “You may have diabetes but it doesn’t have to have you. You are Victorious!” Sheila is Regional Operations Manager for the Near South Region of Access Community Health Network.

Related Content

Our patient empowerment classes have had great success. See our relevant publications for more detail.

Patient Activation

- Patient communication training
  - Culturally tailored diabetes education
  - Shared decision-making
  - 2-3 hr classes x 10 weeks

- Community linkages

- Results:
  - 86% attended ≥ 70% classes
  - Improved self-efficacy, self-mgmt
  - Mean HbA1c: 8.3 → 7.2

- Transition to support groups:
  - Mental health practitioners
  - Group-led focus

- Peer health educators
Culturally Tailoring the Patient Empowerment Classes

**BASICS**

**DISCUSS**

**DEBATE**

**DECIDE**

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**Question 1:**

The doctor says he plans to increase your oral medication intake. You, the patient, do not like taking pills, you should:

**Option:**

a. Say you will take the pills and don’t. You don’t want to rock the boat these days.
b. Say you agree, but do what has been working for you, and keep taking the same amount.
c. Discuss other options with your doctor.

**We recommend:**

c. Discuss other options with your doctor.

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*Can you also find this in the video?*

*Designed by DD+D*
The Role of Narrative

Level

Personal Level

Narrative Characteristics

Personally Engaging Elements:

- **Engaging Characters**
  - Realistic
  - Likeable
  - Homophily (like self)
  - Generates empathy

- **Engaging Story**
  - Appealing storyline
  - Dramatic sequencing

Sociocultural Level

Culturally Engaging Elements:

- **Cultural Embeddedness**
  - Culturally familiar/similar characters
  - Cultural events
  - Culturally resonant language

Mediators

- **Transportation** a.k.a., Engagement or Absorption
- **Identification** with characters, story, and cultural elements
- **Social Proliferation**
  - Discussion/Diffusion
  - Rehaarsal/ reinforcement
  - Reciprocal Support

Outcomes/Responses

- **Attitudes/Beliefs**
  - Perceived Social Norms
  - Intent to Change

- **Behavior Change**

The narrative elements of the class…

**built strong social support** among participants that facilitated **program retention** and **behavioral change**

“Instead of me shunning and pushing away from [the education]…it’s an inspiration because you hear what others go through and we get a chance to share what we’re going through”

“I made so many friends here…I mean we were all friends. We would tell about different experiences and how some of them had really stuck to what they were supposed to do and lost weight. And you know that gave me the incentive. I said, ‘if they can do it, I can do it.’ … I look forward to every three-month [follow-up meeting] because you be running back to your friends.”
Patient Classes: Social Support

• “I was getting tired of carrying that pressure but you know… when I opened up, oh man, I felt like a brick was removed from off of my head because I was able to share what I was feeling. …They listened”

• “She was so concerned about not one, not two. If it was 99 of us she was concerned, explaining and ready to answer any questions that any of us had.”
Leveraging Technology to Enhance Patient Self-Care and Health Care

- Interactive text message reminders
- 4 week pilot at PCG (n=18)

- Improvements in:
  - Diabetes self-efficacy
  - Self-foot examinations
  - Medication adherence
SMS-DMCare
- Text messages
- Phone calls

Daily messages

Health Belief
- Perceived susceptibility
- Perceived severity
- Perceived barriers
- Perceived benefits

Reminders

Diabetes Self-Management

Frequent contact

Feedback

Self-Efficacy
- Mastery experience
- Social persuasion
- Physiological Factors

Social Support
- Perceived support
- Enacted support
- Social integration

Patient Education and Counseling
Texting: Social Support

• The texting program provided participants with someone who cared for and monitored them.

• “But somebody is involved in being concerned about what’s going on with you besides the visits with the doctor or maybe the nurse checking up on you. This is some kind of constant something.”

• Some participants went further to describe the text messaging as a friend, sponsor, or social group.

• “So the texting became a friend to me. And it was telling me, ‘It’s time to take your medicine,’ ‘Did you take your medicine today,’ ‘Did you check your feet.’ So therefore I had someone reminding me.”
Leveraging Technology to Enhance Patient Self-Care and Health Care

- Interactive text message reminders
- 4 week pilot at PCG (n=18)
- Improvements in:
  - Diabetes self-efficacy
  - Self-foot examinations
  - Medication adherence
- UCHP intervention
  - Nurse care manager and healthcare team interface
The Chronic Care Model

- Community
- Health Systems
- Patient
- Practice Team

Productive Interactions

Community Partnerships

Quality Improvement

Provider Training

Patient Activation
Community Partnerships

We partner with community-based organizations and resources, such as the K.L.E.O. Community Life Center, Save-A-Lot Food Stores, Chicago Park District, America Heart Association and a host of other organizations to reach out to high risk communities on the South Side of Chicago and facilitate diabetes self-management, particularly in the area of nutritional changes and physical activity.

We believe that by incorporating programs to support diabetes self-management, these organizations will increase their positive impact on the surrounding community and open doors to more potential partners like the University of Chicago.

K.L.E.O. Community Life Center is located in the catchment area of our intervention, and is an important partner for improving health on the South Side. The K.L.E.O. Center is an official site of the Greater Chicago Food Depository and provides a food pantry on the first Wednesday of each month. Our project partners with K.L.E.O. to provide:

- low-fat, low-sugar and low-sodium recipes along with healthful foods from the pantry. Through cooking demonstrations and food tastings, we show participants how to prepare fresh and healthy meals at a low cost.
- screenings for diabetes and body mass index (BMI).
- information to individuals about medical facilities and clinics participating in the South Side Health Collaborative, which...
Community Outreach and Education

• Regular Source of Care
  – Urban Health Initiative
  – Over 4,000 pts connected to primary care providers

• Public Education
  – Television, Radio, Print
  – Community health venues
  – Center for Community Health & Vitality
The Chronic Care Model

Community

Health Systems

Patient

Practice Team

Productive Interactions

Quality Improvement

Community Partnerships

Provider Training

Patient Activation
Community Partnerships

- KLEO Community Family Life Center
- Chicago Food Depository
- Save-A-Lot Grocery Store
- Walgreens
- Chicago Park District
- Farmer’s Markets
Patient Activation and Community Partnerships

Patient empowerment classes

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

Resources
Reinforcement
Sustainability

K.L.E.O. COMMUNITY LIFE CENTER

Education
Screening
Resources
Integrating Patient Education and Community Partnerships

• “The [food pantry] helps, because it is healthy. I might be running short, and then they kind of fill in, so it all fits in together, it works perfectly…KLEO is there as a community thing and I wouldn’t have known anything about it if it wasn’t for the class. It’s a wonderful thing to know you’re on the right track, that what you’re doing is working. I’m doing what I’m supposed to do, and I’m going to continue.”
Prescriptions for Food and Exercise

- Chicago Park District
- Walgreens
- Farmer’s Market
- Food Depository

Get $5 off your healthy food purchase. See back for more information.

www.SouthSideDiabetes.org  (703) 702-2939

Provider ____________________  Patient ____________________

I recommend the following nutrition for this patient:

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

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

Signature: ____________________  Date: ________________

$5 off your purchase of $20 or more of healthy food

Participating Chicago Locations

5036 S. Cottage Grove Ave.  5737 S. Cottage Grove & 51st St.
(773) 373-6266  (773) 737-6266

650 W. 63rd St.  5737 S. Cottage Grove & 51st St.
(773) 994-4467  (773) 737-6266

1533 E. 67th Pl.
(773) 495-6733

Get $5 off your healthy food purchase. See back for more information.
What are **Low-Carb** Foods?

- Carbohydrates (or carbs) include fruits, sweets and starches.
- The good news is that you don’t have to cut them out. Eating the right portion is important.
- **AIM for 15 grams or less of carbohydrates per serving, and 45-60 grams or less per meal.**

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

What are **Low-Fat** Foods?

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

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

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

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

What are **High-Fiber** Foods?

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

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

What are **Low-Sodium** Foods?

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

- **Careful!** “No salt added” means no salt added during processing; it does not necessarily mean sodium free!

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

- Frozen fruit (no sauce)
- Frozen vegetables (no sauce)
- Whole grain breads
- Horseradish, mustard
- Cream (half & half, whipping)
- Non-dairy creamer
- Spices
- Herbs
- Cream cheese
- Low-salt Cheeses (monterey, mozzarella, ricota)
- Low-salt Crackers (graham, melba toast)
- Popcorn (unsalted)
Save-A-Lot Grocery Store partnership
Early Lessons From An Initiative On Chicago’s South Side To Reduce Disparities In Diabetes Care And Outcomes

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

Racial and ethnic disparities in diabetes care and outcomes arise from multiple causes. These include differential access to high-quality health care, healthy food, and opportunities for safe recreation; cultural traditions regarding cooking; beliefs about disease and self-management; distrust of medical care providers; and socioeconomic status. Consequently, the solution must be multifactorial. Improving patients’ knowledge and increasing their motivation to make healthy lifestyle changes will have minimal impact if their limited and practice are encouraging greater interaction and collaboration among health care providers and communities. One driver of this collaboration is the creation of accountable care organizations, as authorized under the Affordable Care Act of 2010.

Accountable care organizations are likely to have financial incentives to take responsibility for broad health care outcomes and costs for a defined population. Thus, accountable care organizations are potentially motivated to prioritize evidence-based prevention strategies that build on community resources and create a continuum of care from community settings to...

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

Michael T. Quinn is a senior research scientist in the...
Health Policy Relevance: Quality of Care and Health Care Reform

- Medicare payments
  - Quality, performance improvement and care coordination

- CMS Innovation Center
  - Pilot and evaluate different payment structures
  - Quality, patient-centered care and cost containment

- National QI strategy
  - Improve health care delivery, health outcomes, population health

- Collection of race/ethnicity data

- Enhanced Preventive Care
  - No cost-sharing for preventive services
  - Medicaid coverage for tobacco cessation
  - Employee rewards for joining wellness programs
Our Project Team

- Marshall Chin
- Monica Peek
- Tonya Roberson
- Anna Goddu
- Deb Maltby
- Kristine Bordenave
- Michael Quinn
- Doriane Miller
- Lisa Vinci
- Andrew Davis
- Elbert Huang
- Jonathan Birnberg
- Jonathan Dick
- Shantanu Nundy
- Seo Young Park
- Neha Setha
- Emily Lu
- Robert Sanchez

- Deborah Burnet
- Karen Kim
- Dawnavan Davis
- Sheila Harmon
- Quin Golden
- Eric Whitaker
- Shelley Scott
- Mickey Eder
- Peggy Hasenauer
- Louis Philipson
- Marla Soloman
- Hui Tang
- Robert Nocon
- Katie Raffel
- Ndang Azang-Njaah
- Gwen Burrows
- Braunda Anderson
- Melishia Bansa
Thank you!

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

www.southsidediabetes.org