Application for Transformation
Funding Cover Sheet

Primary Contact for Collaboration
American Diabetes Association
Dan Bieritz
Area Executive Director
Illinois and Wisconsin
55 E Monroe St Ste 3420
Chicago, IL 60603
Phone: +1 (312) 346-1805 x6568
Mobile: 
Email: dbieritz@diabetes.org

Collaborators
University of Chicago
Louis Philipson, M.D., Ph.D., FACP
James C. Tyree Professor of Diabetes Research and Care
Departments of Medicine and Pediatrics- Section of Endocrinology, Diabetes and Metabolism
Director, Kovler Diabetes Center
President for Science and Medicine 2019, American Diabetes Association
900 E. 57th Street, KCBD  Room #8140
The University of Chicago, Chicago, IL 60637
Phone: 773-702-9180
Email: l-philipson@uchicago.edu

Northshore University HealthSystems
Romy Block, MD, FACE
Division Chief Endocrinology and Metabolism
Northshore University Healthsystems
9977 Woods Dr. Suite 300
Skokie, IL 60077
Assistant Professor of Medicine, Pritzker School of Medicine
University of Chicago
Phone: (847)663-8540
Email: rblock1@northshore.org

Northwestern Medicine
Amisha Wallia MD, MS
Assistant Professor
Division of Endocrinology, Metabolism & Molecular Medicine
Center for Health Services and Outcomes Research
Northwestern University Feinberg School of Medicine
Contents

Executive Summary .................................................................................................................. 4

Background............................................................................................................................ 4

ADA’s Continued Efforts on Behalf of the People of Illinois.............................................. 4

ADA’s Solution to Transform Healthcare Delivery in Underserved Communities in Chicago................................................................. 7

Diabetes INSIDE®.................................................................................................................. 7

The Institute for Healthcare Improvement ........................................................................... 9

Diabetes Prevention Programs............................................................................................. 10

Community Grants Program............................................................................................... 11

Community Health Worker Training.................................................................................... 13

Community Input................................................................................................................... 13

Data ..................................................................................................................................... 13

Health Equity and Outcomes............................................................................................... 15

Quality Metrics ................................................................................................................... 17

Care Integration and Coordination...................................................................................... 17

Access to Care...................................................................................................................... 17

Social Determinants of Health............................................................................................ 17

Milestones............................................................................................................................. 18

Racial Equity ........................................................................................................................ 19

Minority Participation........................................................................................................... 19

Jobs....................................................................................................................................... 19

Sustainability ......................................................................................................................... 19

Government........................................................................................................................ 19

Industry................................................................................................................................. 19

Employers ............................................................................................................................ 19

Commercial Payers............................................................................................................ 20

Governance Structure ......................................................................................................... 20
Executive Summary

Background
Since 1940, the American Diabetes Association (ADA) has been the leading national authority on managing and treating diabetes. We have always centered and prioritized community; the 122 million people living with diabetes and prediabetes guide our decisions, our strategy, and our commitment to social justice.

Today, ADA is helmed for the first time by a person living with diabetes – Tracey D. Brown, an African American woman with Type 2. Tracey and her team work hard to build emotional connections and trusted relationships with our members to help communities who bear the greatest burden of the disease navigate the healthcare system and manage their care. In addition, to ensure those living with diabetes get the best care possible, we have become a leading resource on clinical standards and care guidelines for diabetes healthcare providers.

We have deep experience in healthcare transformation initiatives and are currently leading a large population health improvement collaborative centered in Greater Philadelphia and extending to NJ and MD that includes leading medical centers like Jefferson Health, Temple Health, Penn Medicine, Johns Hopkins and Hackensack Meridian Health. This initiative, called Diabetes INSIDE®, has improved care for hundreds of thousands of patients with diabetes, often in underserved areas, and we aim to replicate our successful approach to benefit communities in Illinois.

ADA’s Continued Efforts on Behalf of the People of Illinois
The impact of diabetes on the people of Illinois goes beyond physical effects, taxing emotional and mental well-being; from discrimination at work or school, to stress of constant self-care and monitoring, to massive health care costs that are twice as high as for people without diabetes. This translates to a colossal impact on the Illinois economy; costing $3.2 billion per year in lost productivity alongside the $8.7 billion of direct medical expenses for diagnosed diabetes. The burden of diabetes is imposed on all sectors of society, resulting in higher insurance premiums, reduced earnings, productivity loss, and reduced quality of life for people with diabetes, their families, and their communities.

ADA has a network of more than 515,000 Diabetes Advocates nationwide, with 26,674 of those residing in Illinois. In 2020, our Legal Advocates handled 61 discrimination cases to help those who have experienced prejudice in their lives because they have diabetes.

As a result of our 2020 advocacy efforts, Illinois became the second state to pass legislation to cap co-pays for insulin. Governor J.B. Pritzker recently signed legislation that limits the total amount that a person is required to pay for a 30-day supply of insulin at an amount not to exceed $100, regardless of the quantity or type of insulin used to fill the prescription – a major win for people and families affected by diabetes!

Also, in 2020, we offered the ADA Imagine Camp experience to all children ages 5-17 living with type 1 diabetes and their families and were able to serve over 200 children and teens living with type 1 diabetes in Illinois.

ADA and Top Box Foods have worked together in 2020 and 2021 to help those in need due to the COVID-19 pandemic. With this collaboration we have delivered healthy food boxes to over 35,000 individuals across the city of Chicago, specifically to low-income households in the South and West sides of Chicago and the
East side of Aurora, typically identified as food deserts and where individuals are at higher risk for type 2 diabetes. In addition to nutritional items, the ADA included diabetes-related educational and nutritional information.

ADA maintains an active regional team in Illinois through our dedicated field staff and community leadership board, members of which are listed below. This team is well positioned to advance a shared goal of transforming healthcare to help Medicaid beneficiaries in distressed communities in Chicago.

**EXECUTIVE COMMITTEE:**

Michele Hansen, M.S. / Chair  
Health System Account Manager / Novo Nordisk Inc.

Amisha Wallia MD, MS / President  
Assistant Professor / Center for Healthcare Studies  
Northwestern University / Feinberg School of Medicine

Dan Bieritz / Staff  
Executive Director, Illinois

**BOARD EMERITUS MEMBERS:**

Louis H. Philipson, MD, PhD / National Board Member  
Professor of Medicine & Pediatrics, Director /  
University of Chicago / Kovler Diabetes Center

Amy B. Manning, JD / Past Chair  
Partner & Global Department Chair, Antitrust, Trade & Commercial Litigation Department / McGuireWoods LLP

**MEMBERS AT LARGE:**

Guillermo Amezcua  
Area Vice President, Marketing & National Account Sales /  
Baxter International

Sheila Harmon, RN, MSN, APN, CDE  
Director of Provider Practice, Mile Square Health Center /  
University of Illinois Hospital & Health Sciences System

Kathleen M. Gallagher  
SVP Retail Banking / Wintrust Bank

Aristotle S. Kornaros  
CEO / Dietitians at Home, inc

Brian Layden, MD, PhD  
Chief, Division of Endocrinology, Diabetes & Metabolism /  
University of Illinois at Chicago

Alissa Luck  
VP of HR & Global Talent / IDEX Corporation

Jennifer L Miller, MD  
Attending Physician / La Rabida Children’s Hospital /  
Ann & Robert H. Lurie Children’s Hospital of Chicago

Matthew J. O’Brien, MD  
Assistant Professor at Northwestern University, Feinberg School of Medicine / Northwestern Medical Group

Alaina Kennedy  
Chief Operating Officer / Illinois Association of Medicaid Health Plans

Mary Olges  
Managing Director, Worldwide Commercial Business / Microsoft

Mike Parkis  
Senior Director / Divisional Merchandise Manager of Advanced Care / Walgreens Boots Alliance

Veena Raiji  
Clinical Assistant Professor / Loyola University Medical Center

Kevin Stroud  
Executive Territory Business Manager / Dexcom

Mitch Rosen  
Program Director / CBS Radio

Michelle Toscas  
Managing Director/ W2O

Celeste C. Thomas, MD, MS  
Assistant Professor of Medicine / University of Chicago

Ross Westreich  
Vice President and Executive Director /  
Humana’s Medicaid Market Operations in Illinois

Karie J. Valentino  
Partner / Lewis Brisboi
ADA’s National Health Disparities Committee, comprised of leading health equity and community health experts, serves to advise the Association’s work around reducing inequities facing populations disparately affected by diabetes. The Committee provides expert guidance in the areas of effective community support, program criteria and evaluation, trends in health equity strategies as applicable across the spectrum from consumers to providers and clinics to community, and strategies for the Association to effectively contribute to the diabetes ecosystem as it relates to disparities reduction.

### 2021 Health Disparities Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrique Caballero, MD</td>
<td>Brigham and Women’s Hospital, Harvard Medical School, Boston, MA</td>
</tr>
<tr>
<td>Betsy Rodriguez, MSN, CDE</td>
<td>Centers for Disease Control and Prevention, Division of Diabetes, Atlanta, GA</td>
</tr>
<tr>
<td>Samereh Abdoli, PhD, RN</td>
<td>College of Nursing, University of Tennessee-Knoxville, Knoxville, TN</td>
</tr>
<tr>
<td>Shivani Agarwal, MD, MPH</td>
<td>Fleischer Institute for Diabetes and Metabolism, NY-Regional Center for Diabetes Translational Research, Albert Einstein College of Medicine, Bronx, NY</td>
</tr>
<tr>
<td>Erika Anna, MS, RDN, CD</td>
<td>University of Wisconsin - Madison, Department of Nutritional Sciences, Madison, WI</td>
</tr>
<tr>
<td>Arshiya A. Baig, MD, MPH</td>
<td>Department of Medicine, Chicago Center for Diabetes Translation Research, University of Chicago, Chicago, IL</td>
</tr>
<tr>
<td>Durrell Fox, BS, CHW</td>
<td>JSI Research and Training, John Snow Inc., Atlanta GA</td>
</tr>
<tr>
<td>Danielle Gilliam, PharmD, MPH</td>
<td>Novo Nordisk Inc., Chandler, AZ</td>
</tr>
<tr>
<td>Lois Maurer, MS, RD, LDN</td>
<td>Joslin Diabetes Center, Boston, MA</td>
</tr>
<tr>
<td>Lisa Scarton, PhD, RN</td>
<td>University of Florida, Gainesville, FL</td>
</tr>
<tr>
<td>Joseph A. Stankaitis, MD, MPH</td>
<td>Monroe Plan for Medical Care / University of Rochester School of Medicine and Dentistry, Pittsford, NY</td>
</tr>
<tr>
<td>Lisa Taylor, DNP, MSN, BSN</td>
<td>College of Nursing, New Mexico State University, Albuquerque, NM</td>
</tr>
<tr>
<td>Traci Thompson, MD, MBA, CPE</td>
<td>Dr. Traci’s House, Inc., Tampa, FL</td>
</tr>
<tr>
<td>Paula M. Trief, PhD</td>
<td>State University of New York (SUNY), Upstate Medical University, Syracuse, NY</td>
</tr>
<tr>
<td>Ashby Walker, PhD</td>
<td>University of Florida Diabetes Institute, Gainesville, FL</td>
</tr>
<tr>
<td>Hsin-Chieh “Jessica” Yeh, PhD</td>
<td>Johns Hopkins University School of Medicine, Baltimore, MD</td>
</tr>
<tr>
<td>Clipper Young, PharmD, MPH, CDCES, BC-ADM, BCGP, APh</td>
<td>Touro University California, College of Osteopathic Medicine, Vallejo, CA</td>
</tr>
<tr>
<td>Rong Mei Zhang, MD</td>
<td>Washington University, St. Louis, MO</td>
</tr>
<tr>
<td>Caroline Blanco, MS, RDN, LDN</td>
<td>(ADA Staff Liaison), American Diabetes Association, Arlington, VA</td>
</tr>
</tbody>
</table>
Presently, ADA is partnered with the Baxter International Foundation, Abbott Diabetes Care, and Walmart through our newly launched Health Equity Now Initiative to address barriers to diabetes management in Chicago and surrounding areas. This platform brings together partners to ignite action and dismantle the systematic health inequities that plague our country and underserved communities.

ADA is requesting $10,000,000 in funding over three years to build and sustain a health care transformation collaborative targeting underserved regions in Chicago and surrounding communities to reduce health disparities in diabetes.

We encourage you to review the attached summary of ADA programs, products and services that will guide our efforts to improve care for people in underserved communities in Illinois. Also attached are supporting documents listing our collaborating partners and publications describing our healthcare transformation work in other regions. On behalf of the people with diabetes we all serve, thank you for your consideration of this proposal.

**ADA’s Solution to Transform Healthcare Delivery in Underserved Communities in Chicago**

Our overarching goal is to prevent progression to diabetes and improve outcomes for people with existing diabetes in underserved communities in the Greater Chicago region. To accomplish this, ADA will build and manage a regional healthcare transformation collaborative featuring the following initiatives:

- **Diabetes INSIDE®** is our quality improvement (QI) and population health framework that engages healthcare systems to transform the way they deliver care for people with diabetes. We will recruit and form multidisciplinary teams of primary care, cardiology, endocrinology, nephrology, pharmacy, health IT and diabetes support staff at four Chicago-area health systems and facilitate their improvement projects to achieve the above goals.
  - University of Chicago
  - NorthShore HealthSystem
  - Northwestern Medicine
  - University of Illinois, Chicago

- In collaboration with the Institute for Healthcare Improvement (IHI) we will deploy a 10-month training and learning collaborative to ensure equity-driven diabetes outcomes that close the gaps in type 2 diabetes care.

- We will stand up four new National Diabetes Prevention Program (DPP) locations in underserved communities in Chicago, train health coaches to staff them and work with our healthcare partners to refer patients to the program. We will track data and outcomes for participation using our DPP Express platform.

- We will train Community Health Workers (CHWs) and identify and support minority-led community organizations that provide services to address social determinants of health challenges that impact people in these underserved communities.

**Diabetes INSIDE®**

The American Diabetes Association’s Diabetes INSIDE® (**IN**spiring **S**ystems **I**mprovement through **D**ata-Driven **E**xcellence) initiative aims to translate over 80 years of our research and advocacy into action by supporting our nation’s healthcare systems to improve population health for people with diabetes. Diabetes INSIDE® is a national, multi-sector framework that leverages ADA’s expertise in diabetes and
strength as a trusted convener to sustain long-term engagement by healthcare stakeholders to continually improve healthcare delivery and coordination across regional and local ecosystems.

Diabetes INSIDE® is designed to catalyze, accelerate and sustain existing, but often siloed, healthcare improvement projects across health systems, public health departments, payers, industry, federal, state and local governments, large employers, community services, nonprofits and philanthropic organizations. ADA’s Standards of Medical Care in Diabetes, widely recognized as the gold-standard in diabetes management guidelines, give ADA both a responsibility and a mandate to guide healthcare stakeholders in translating this comprehensive body of knowledge into action.

Improving diabetes population health transcends any one stakeholder and requires a multi-sector framework to enact meaningful change. Improvements must be facilitated at the system level using an ethnographic approach that accounts for the resources, policies, goals, values and demographics of unique healthcare markets. Socioeconomics and regional context are critical to defining and testing solutions that are effective in disparate settings. There is no one-size-fits-all solution to a problem the magnitude of diabetes.

Diabetes INSIDE® provides a framework for transformational change and collaboration by targeting all levels of the healthcare ecosystem. By combining data science and improvement methodologies with a long-term commitment and mission to improve the lives of people with diabetes, ADA is uniquely positioned to facilitate and sustain a multi-sector, multi-year regional improvement initiative to accelerate the diffusion of innovation and reduce the burden of diabetes and its comorbidities for underserved communities in Chicago.

Population Health Data Science
It is difficult to improve what you cannot measure. Evaluation and population health analytics are built into the Diabetes INSIDE® framework, with ADA’s Standards of Medical Care in Diabetes providing the evidence for measuring processes and outcomes in diabetes population health and using these data to inform change.

Care System Re-Design & Shared Learning
All improvement requires change, but the status quo is persistent and stubborn. Diabetes INSIDE® provides training, coaching and facilitation in change management and improvement methodologies, and taps into ADA’s robust professional network to connect our partners with one another and to support them with expertise and guidance.

Healthcare Provider Support
Knowledge is the foundation on which all change is built. Diabetes INSIDE® includes professional education and training opportunities for all healthcare professionals, and tailors the educational content using real-world data to determine needs and develop relevant interventions.

Community Integrated Health
Most people with diabetes spend less than 1% of their time in healthcare settings. ADA provides a bridge between healthcare systems and community resources and organizations to support people and populations in disease prevention and management in the communities where they reside.
**Patient Engagement**

People with diabetes are their own primary care providers. ADA has a long history of engaging patients to improve their knowledge, skills, ability and willingness to manage their own health. Diabetes INSIDE® incorporates patient education and engagement activities throughout.

**Recognition, Dissemination & Advocacy**

Scalability requires a platform for sharing successes and challenges openly and transparently. Diabetes INSIDE® leverages ADA’s publications, distribution channels and professional networks to catalog and disseminate change, while recognizing participating individuals and organizations publicly for their important efforts. ADA’s advocacy team then uses the real-world evidence generated through Diabetes INSIDE® to champion better health policies at the local, state and federal level.

**The Institute for Healthcare Improvement**

The Institute for Healthcare Improvement (IHI) is a leading innovator in health and health care improvement worldwide. For more than 25 years, IHI has partnered with visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Recognized as an innovator, convener, trustworthy partner, and driver of results, IHI is the first place to turn for expertise, help, and encouragement for anyone, anywhere who wants to change health and health care profoundly for the better. ADA will collaborate with IHI to deliver the following 3-phase program targeting undeserved regions in Chicago:

**Phase I - Leadership Engagement in Prioritizing Diabetes Outcomes (Months 1-4)**

Leadership engagement is a critical driver of sustainable change for any health system. In partnership with ADA, IHI will identify and initiate discussions with potential healthcare partners in a prototyping initiative. Our goal in Phase I will be to work with the above-mentioned Chicago health systems and leverage a tested process to identify a limited set of shared diabetes and health equity measures. Our work in these four months will include guidance on will-building among core leadership and key stakeholders; identification of a framework and measures for equitable diabetes care; understanding and advancing existing and past improvement efforts; validating an evidence-based educational approach for improvement; and identifying the participants for advanced quality improvement training. Strategic support includes virtual planning meetings and a regular cadence of coaching calls with expert faculty.

**Phase II - Engaging Front Line Care Givers in the Improvement Practicum (Months 4-10)**

As practitioners in the participating health systems are identified, IHI will engage them in an Improvement Practicum. The Improvement Practicum Program is a pragmatic, intensive course that guides participants through the application of improvement methods to a set of strategic projects and work together as a learning and improvement cohort to test changes and measure results toward their aims. The program is designed to quickly train people engaged in organizational improvement projects in the use of methods and tools by applying them directly to project work with an aim on achieving results.

Participants learn about improvement methods, including the Model for Improvement, Plan Do Study Act (PDSA) cycles, process mapping, use of data for improvement, and how to best apply the sequence of improvement (i.e., testing, implementing, sustaining and spreading new ideas). The program focuses on experiential learning, as participants combine actual improvement efforts with theory intended to reinforce their ongoing work. The program includes:
• Workshops. These intensive workshops deliver direct instruction in improvement methods, build enthusiasm and will for change, and facilitate peer-to-peer learning among teams to share their successes and other experiences.

• Action Periods: Between Workshops are “Action Periods” where the core work happens. Teams work in their home departments to implement and measure small tests of change designed to achieve the desired improvements. During these phases, teams report on their testing and receive regular coaching. Virtual open coaching calls are also scheduled each month for teams to have peer-to-peer learning through sharing their work, discussing challenges, and problem solving.

• Ongoing harvesting and curation of the learning from participating teams. These findings inform change packages by the end of the Practicum that can support the scale up of interventions that will generate impact at scale over time.

Phase III - Equity Action, Sprint, and Momentum Lab - Engaging Frontline Providers and Community Stakeholders (Months 6-10)

To improve diabetes outcomes and spread what works beyond the individual health systems, teams will recruit a coalition of community organizations to join an Equity Action, Sprint, and Momentum Lab. An Equity Action, Sprint, and Momentum Lab is a flexible and adaptable model to bring together a diverse group of stakeholders to take action in pursuit of equity and community improvement. The model was built using human-centered design principles, which puts the people most affected by the inequities, or the problems in a system, at the center of designing new solutions.

Prep work can begin during the Improvement Practicum phase by reviewing existing data, refining the topic areas to be addressed, and recruiting diverse team members to be involved in the subsequent phases. The Action Lab (1.5-2 day virtual meeting) brings together those who will be doing the work. An “action team” includes those who are most affected by the issue(s) as experts in the codesign of solutions. Participants set an ambitious goal to be achieved within a limited timeframe and design a flexible plan to achieve their goals. The plan includes actions/tasks and deadlines for these actions, and it delegates responsibility for completing them. This team holds full decision-making authority. The action team may include and may call on the leaders who were engaged during the set up to help them bring about their vision.

Immediately following the Action Lab, the Sprint Phase begins. In a short time period (generally 100 days, depending on what the community decides), initial theories will be tested and then refined through a series of regular (often weekly) check-ins. Finally, the Sustain Phase begins with a Momentum Lab (1.5-2 day virtual meeting) where progress and learning are celebrated, and discussions are held about how to maintain and build upon the achievements. The duration of this phase varies widely depending on the topic area and context.

Diabetes Prevention Programs

The ADA Standards of Medical Care in Diabetes recommends that providers refer patients with prediabetes to a lifestyle change program that is modeled on NIH’s Diabetes Prevention Program (DPP). CDC-recognized lifestyle change programs use curricula modeled on the DPP providing high-risk patients with a focused, evidence-based intervention that provides professional help to make small but impactful, lasting changes. Year-long sessions are facilitated by a trained lifestyle coach with a focus on nutritional and physical activity modifications that can reduce the risk for or delay type 2 diabetes.
• Research shows DPP-based/CDC-recognized lifestyle change programs are effective at preventing or delaying type 2 diabetes.
• Diabetes onset is expected to be delayed by 11.1 years with the lifestyle change program compared to 3.4 years with metformin.
• People who lost between 5% and 7% of their body weight had a 58% lower incidence of type 2 diabetes.
• A total of 5% of participants developed diabetes compared to 11% of group members who received a placebo instead. The program has lasting results, showing that participants had a 34% lower rate of type 2 diabetes 10 years after they had completed the program.

CDC recognized lifestyle change programs are based on the Diabetes Prevention Program Study and has found to cut the risk for developing diabetes by 58% or 71% in people over 60. Lifestyle change programs will be stood up in underserved areas and will target participants that are at highest risk of developing type 2 diabetes utilizing community health workers and adaptations that are both culturally and linguistically appropriate to ensure that the program will resonate with the people in the community.

Our goal in Chicago is to support existing National DPP lifestyle change programs and stand up new programs targeted in four underserved communities:
• Chicago South Side
• Chicago West Side
• South Cook County
• West Cook County

We will actively train new coordinators and lifestyle coaches to support these National DPP lifestyle change programs and provide a reporting infrastructure for DPP sites to track referrals, patients’ progress and implement billing with payers toward developing a long-term, sustainable practice through reimbursement.

The ADA will provide training and technical assistance to CDC-recognized lifestyle change programs to meet the needs of the population that they are serving including reducing barriers to attending and successful completion of the program. Resources may include access to healthy food, childcare or transportation.

Community Grants Program
Racial/ethnic minority groups, including African American and Hispanic/Latino populations have higher rates of diabetes with significantly higher risk of complications compared to non-Hispanic Whites. Diabetes support programs have been shown to reduce complications and improve overall health and quality of life, but unfortunately, are not readily available in health disparate communities. The ADA Community Grants Program supports community health organizations in providing Diabetes Self-Management Support (DSMS) programs and resources. These culturally relevant diabetes support programs are an essential component of diabetes care and can be modeled by various organizations and communities nationwide, creating clinical and community linkages that are proven to have the greatest impact on health.

The ADA Community Grants Program will provide funding to support four community-based organizations per year who provide services to disparate communities in the greater Chicago area. Goals for each Community Grant recipient who receive this support include:
• Deliver ADA approved Diabetes Support Health Lesson and Patient Education resources. *(ADA to provide electronic materials available in English and Spanish)*

• Recruit and enroll a minimum of 250 participants (ages 18 and older) to participate in the ADA approved Diabetes Support Program. *(Participant outreach efforts focused on the Hispanic/Latino and African American population)*

• Increase the proportion of people living with prediabetes and type 2 diabetes engaged in the program to have an increase in knowledge and awareness of recommended healthy lifestyle changes to prevent and/or better manage their condition.

• Increase the proportion of individuals with T2D that have discussed their risk for heart disease with their healthcare provider.

• Drive at least 70% of participants engaged in the Program in at least one health action or behavior to better manage their condition and risk of CVD. *(E.g., made changes to diabetes regimen to better control blood glucose, actively tried to follow healthy eating patterns)*

In support of this Community Grants Program, ADA will:
1. Designate a primary contact to serve as point of contact for the ADA Community Grant;
2. Provide Grantee the ADA resources available in English and Spanish, that include but are not limited to health lessons, presentations, and patient education materials, to be utilized as part of Grantee’s ADA approved Diabetes Support Program;
3. Provide Grantee information on the ADA’s Ask the Experts monthly series and participant online enrollment process for Living with Type 2 Diabetes;
4. Host quarterly calls with Grantee to receive Program summary updates; and
5. Provide promotion of Grantee’s Diabetes Support Program through the ADA’s communication channels including, but not limited to the ADA community networks, professional members, and social media platforms.

Community Health organizations who receive funding from ADA from this program will:
1. Designate a primary contact to serve as point of contact for the ADA Community grant;
2. Provide a 2021 project plan with milestones and timeline for deliverables;
3. Integrate the ADA Health Lesson and Patient Education resources as part of the ADA approved Diabetes Support Program;
4. Recruit and enroll up to 250 participants with prediabetes and type 2 diabetes to participate in the ADA approved Diabetes Support Program with participant outreach efforts focused on the Hispanic/Latino and African American population in health disparate areas;
5. Promote the ADA’s Ask the Experts series to participants to join via online or telephonically;
6. Promote the ADA’s online Living with Type 2 Diabetes program to participants with type 2 diabetes;
7. Identify 5 participant “Success Stories” to highlight and share participant testimonials for promotions;
8. Participate in quarterly calls with the ADA to provide Program summary updates (programmatic and financial); and
9. Complete and submit all required mid-term and final reporting (programmatic and financial) including, but not limited to the evaluation of:
a. Program Delivery: To provide documentation of how the ADA Community Grants Program and resources are integrated into the Program delivery

b. Process Metrics: To include the extent to which the program was delivered (e.g., number of participants recruited, enrolled, and completed the program, number of participants referred to Living with Type 2 Diabetes) and to whom (e.g., demographics)

c. Participant Outcomes:
   i. Knowledge: Proportion of participants with improvements in diabetes knowledge.
   ii. Behavior: Percent of participants who engage in at least one health action or behavior to better prevent or manage type 2 diabetes
   iii. Additional outcomes as collected per the Diabetes Support Program - Participant behavioral changes for improved and reinforced diabetes-related knowledge, self-care skills (in areas such as meal planning, physical activity, medication taking, and blood glucose monitoring).

Community Health Worker Training

As part ADA’s strategic plan to help people living with diabetes and their families thrive, ADA continues to prioritize health disparities and health equity through our various Mission initiatives.

Community Health Workers (CHWs) are trusted, knowledgeable frontline health workers who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and help to improve health outcomes. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, and social support.

ADA’s CHW training programs are designed by our National Health Disparities Committee (described above). Our committee includes Arshiya A. Baig, MD, MPH, FACP, Associate Professor, Section of General Internal Medicine, Department of Medicine and Associate Director, Chicago Center for Diabetes Translation Research, at the University of Chicago.

Dr. Baig and others on the committee will be highly involved designing a training program to engage Chicago-area CHWs and will focus on deploying CHW’s to areas where they are needed most. We will work to engage CHWs from across the city of Chicago, including those affiliated with our health system partners, to provide them with evidence-based training and support to best support the people with prediabetes and diabetes that they serve.

Community Input

Our comprehensive vision outlined in this proposal combines the expertise of our extensive Chicago-area network of healthcare partners, board members, and community organizations with a data-driven approach that leverages existing community health needs assessments and baseline population health data analyses to identify the most opportune targets for intervention.

Data

ADA deploys a rigorous approach to data collection, analysis and reporting that securely and comprehensively maps regional diabetes outcomes and generates insights to guide healthcare
transformation initiatives. Please see the attached peer-reviewed publications in *Diabetes Care* and *Diabetes Spectrum* for additional detail into our methodology and results.

ADA will partner with the HealthShare Exchange (HSX), a regional Health Information Exchange (HIE) to support data collection, sharing and analysis for the Diabetes INSIDE® initiative. HSX will provide the following services over the course of this 3-year initiative. Through a combination of its full-time staff, healthcare members, expert consultants, and professional committees and workgroups, HSX is well positioned to enhance ADA’s capabilities to improve population health for people with diabetes.

**Population Health Data Collection, Management and Analysis**

HSX will leverage its above-mentioned assets to support ADA’s population health data needs listed below and will expand on its existing participation and data sharing agreements with ADA to include these additional services:

- Population health data collection to include:
  - Study populations: All adults (≥18 yo) with one or more documented cardiometabolic disorders, including T2DM, prediabetes, CVD, PVD, CVA, dyslipidemia, hypertension, elevated BMI, CKD, etc., diagnosed over last 2-10 years from primary care, endocrinology, nephrology, and cardiology departments without exclusions for dates or durations of care. At least two longitudinal, time-series data sets per system are collected to establish baseline system performance and to assess system performance resulting from quality improvement activities.
  - Data elements:
    - Patient demographics
    - Insurance
    - Provider attribution
    - Referrals
    - Vital signs
    - Laboratory data
    - Medications
    - Health maintenance
    - Diagnostic and procedure codes
- Population health data validation to include normalizing data sets and cleaning EHR data by rejecting observations with incompatible data types
- Population health data analysis and visualization: after extensive data cleaning, parsing, and correlating procedures to identify, standardize, and flag missing, out-of-range, incomplete, or unanalyzable (in raw format) data, multiple analyses and models are constructed to illuminate care quality outcomes using single and multi-variate numerical and categorical analysis, time-to-event (Kaplan-Meier and Cox proportional hazards models) analysis, time-series analysis using statistical process control techniques, and predictive models (clustering, classification and regression trees, generalized additive models, Gaussian mixture models, support vector machines, neural nets, etc.)
- Population health data security and storage
- Data sharing policy and contracting
- Statistical package programming, optimization, debugging and reporting: Analysis and modeling generates hundreds of results and graphs that are distilled into presentations and reports for
provider teams to help drive system-level changes in practice that drive measurable care quality improvements. Training and coaching in quality improvement methodologies and system-change strategies is also provided to support provider-led initiatives to reorganize and improve care. Additional support is provided for publications and shared-learning events reporting results of quality improvement efforts.

HSX will leverage ADA’s existing data analysis framework and ADA guideline-driven protocols to collect and analyze data from ADA’s partner health systems.

These services will be applied by HSX on behalf of ADA in accordance with ADA’s existing project plan for Diabetes INSIDE® to:

- Facilitate the collection, validation and analysis of de-identified population-level data obtained from the following ADA health system partners:
  - University of Chicago Medicine
  - Northwestern Medicine
  - NorthShore HealthSystem
  - University of Illinois Hospital and Health Sciences
- Provide detailed analysis of the above data sets to:
  - Generate feedback reports for health system QI teams and for use in shared learning activities.
  - Monitor changes to clinical processes and outcomes
  - Communicate findings across the Diabetes INSIDE collaborative
  - Report outcomes to ADA’s funding partners

Health Equity and Outcomes

ADA’s Health Equity Bill of Rights guides our interventions to tackle health disparities. Combined with our rigorous approach to data collection and quality improvement, we will focus on reducing health inequities in the Black and Latino/Hispanic populations in Chicago to close the gap in diabetes prevalence and poor diabetes outcomes that these populations face.

The current health pandemic and its disproportionate toll on minority, low-income, and historically underserved Americans shines a troubling light on historic, systemic inequities in American health care. It is time for health equity now. The Health Equity Bill of Rights envisions a future without unjust health disparities. It ensures the 122 million Americans living with diabetes and prediabetes, along with the millions more who are at high risk for diabetes – no matter their race, income, zip code, age, education or gender – get equal access to the most basic of human rights: their health. These rights include:

1. The right to access insulin and other drugs affordably. People with diabetes account for $1 of every $4 spent on health care in our country, and growing numbers cannot afford the medications they need to survive. One in four insulin-dependent people with diabetes say they ration their insulin. People with diabetes should be able to get the medication they need without having to choose between filling their prescription, paying rent, or putting food on the table.
2. The right to healthy food. The poorer you are in America, the less likely you are to have a grocery store within walking distance of your home. Diabetes rates are inversely related to income level, and nutrition is critical to diabetes prevention and management. Every American with diabetes and
prediabetes must have access to affordable, culturally relevant food and the information they require to eat healthfully.

3. The right to insurance that covers diabetes management and future cures. Diabetes is the most expensive chronic condition in the U.S., and people with diabetes incur medical costs nearly two and a half times higher than others. Costs skyrocket for Americans who have diabetes but who do not have insurance – they are hospitalized nearly 170% as often, compounding their risk for complications and leaving them medically worse off than if they sought care earlier. To start bridging disparities in diabetes care, it is essential that all people with or at risk of diabetes are covered by robust health insurance.

4. The right not to face stigma or discrimination. Even though Americans with diabetes are legally protected against discrimination at work and school, the diabetes community still faces many barriers to equal treatment. Children with diabetes have too often been refused treatment in school, and frontline workers too often refused the ability to manage their condition on the job. Every American with diabetes should be able to live and work free of discrimination and stigma.

5. The right to avoid preventable amputations. Every 4 minutes in America, a limb is amputated due to diabetes – and most are avoidable. The risk of amputation rises among communities of color; African Americans suffer diabetes-related amputations more than twice as often as whites. Every American with diabetes should have access to the care necessary to prevent diabetes-related amputations.

6. The right to participate in clinical trials without fear. Though Americans of color are nearly twice as likely to have diabetes and related chronic diseases as whites, there is inadequate diversity in clinical trials to test drugs that people with diabetes need. Given the troubling history of mistreatment of minorities in medical research, every effort must be made not just to invite a diverse range of participants in drug trials, but to also ensure participants are protected by and in the process. Drugs and treatments utilized for diabetes care should be created with the diverse populations that use them and the unique risks they face in mind.

7. The right to stop prediabetes from becoming diabetes. Diabetes care should not start at diagnosis – it should begin long before. Even though prediabetes and Type 2 diabetes are often preventable, low-income, minority, and historically underserved communities still see the highest incidence. Every American should have access to culturally and linguistically appropriate diabetes testing, care, counseling, and other resources necessary to prevent diabetes onset.

8. The right to a built environment that does not raise the risk of getting diabetes. Historically underserved communities not only see the highest diabetes rates, but also face the greatest barriers to safe places to live and exercise, to clean air, and clean water – the things that mitigate diabetes onset and related risks for others. All Americans are entitled to access to an environment that allows for a healthy lifestyle.

9. The right to the latest medical advances. Medical technologies like continuous glucose monitors, insulin pumps, and artificial pancreases can be instrumental in treating and managing diabetes. Still, many people with diabetes in the lowest income brackets do not have the same access to these life-saving technologies as do higher income peers. The latest advances in diabetes management should be accessible for all who stand to benefit in tandem, communicated in culturally relevant ways, and prioritize the protection of patient data.

10. The right to have your voice heard. Every community should have a say in how their needs can best be addressed everywhere from the doctor’s office to the ballot box. In our new post-COVID reality,
things as simple as visiting family, going to the grocery store, or even leaving your home can pose grave danger for people with diabetes and others facing a heightened threat during this pandemic. Every American should be able to exercise their civic duty safely, regardless of underlying medical condition.

Quality Metrics
Diabetes INSIDE® is well-aligned with the Department’s Quality Strategy and is specifically designed to improve care for people with prediabetes and diabetes, focusing on comprehensive diabetes management and prevention guidelines as defined by our own Standards of Medical Care in Diabetes. Our guidelines are often used to define quality metrics based on the best available evidence for achieving good diabetes control. Diabetes INSIDE® focuses heavily on modifiable risk factors like weight management, cholesterol, blood sugar and blood pressure control; by improving these measures of health we aim to prevent the serious complications of diabetes like heart disease, kidney disease, blindness and amputations.

Care Integration and Coordination
There exists a significant knowing-doing gap in the prevention and management of diabetes. Healthcare stakeholders are constantly developing new therapies, technologies, policies and partnerships to tackle this problem. Though often promising, these endeavors have been slow to effect meaningful improvements; population health in diabetes is worsening and the status quo is simply untenable.

Healthcare policies and innovations developed by our health systems, payers, governments, and leading corporations may take decades to translate to real-world practice and often only impact those who are already engaged in their health and wellness or can afford the latest breakthroughs. Healthcare partnerships are typically built on short-term business objectives and mired in bureaucracy, with timelines measured in months and years, when a much longer time horizon is required.

Care integration and coordination is a central lever to overcome this knowing-doing gap. By directly addressing healthcare processes and workflow, Diabetes INSIDE® is able to fundamentally shift how healthcare providers work together to improve patient care.

Our work in Philadelphia, which shares many sociodemographic challenges with Chicago, revealed an important trend in care coordination; 61% of patients with cardiometabolic disorders receive care from multiple healthcare systems. This raises the importance of forming healthcare transformation collaboratives and building solutions that allow providers to communicate and coordinate effectively across organizations.

Access to Care
By improving care integration and coordination through Diabetes INSIDE®, standing up new Diabetes Prevention Programs and directly supporting community health organizations, ADA aims to expand access to care to the most vulnerable in the greater Chicago region.

Social Determinants of Health
Our Diabetes Prevention Program, Community Grants Program and Community Health Worker training initiative are designed specifically to address social determinants of health challenges. These initiatives
train healthcare providers and build capacity in underserved regions to tackle food insecurity, transportation and access issues that present barriers to achieving better health outcomes. Our Diabetes INSIDE framework provides extensive data analysis and insight generation to identify and act on SDOH gaps.

**Milestones**

**Diabetes INSIDE**
- Months 1-6: Complete health system enrollment, onboarding and data sharing agreements
- Months 6-12: Collect and aggregate population health data, finalize QI project goals for each health system
- Months 12-16: Report out baseline findings, launch first shared-learning meeting series
- Months 16-24: Monitor improvement projects, launch second shared-learning meeting series
- Months 24-30: Scale successful interventions more broadly, develop publication plan
- Months 30-36: Launch final shared-learning meeting series, collect and analyze data for comparative assessment against project goals, finalize publication plan.

**Institute for Healthcare Improvement**
- Described above

**Diabetes Prevention Program**
- Months 1-3: Develop and deploy RFPs to identify 4 organizations to stand up and deliver the National DPP lifestyle change program in underserved regions of Chicago
- Months 3-6: Train lifestyle coaches and program coordinators from the 4 affiliate sites on implementation of the National DPP lifestyle change program.
- Months 6-36: Deliver the National DPP lifestyle change program to underserved populations in underserved areas.
- By Month 30: All affiliate site organizations will have achieved full CDC recognition for their program.
- By Month 36: Affiliate site organizations will have applied to become MDPP Suppliers and have developed plans for billing for the service.

**Community Grants Program**
- Months 1-3: Develop and deploy RFPs to identify organizations to deliver Community Grant Diabetes Support Program in underserved regions of Chicago
- Months 4-5: Program training and launch
- Months 6-12: Participant Outreach + Enrollment / Program Delivery / Analysis
- Months 12-14: Identify new organizations or resource successful orgs from year 1
- Months 14-24: Additional patient outreach and enrollment
- Months 24-25: Identify new organizations or resource successful orgs from year 2
- Months 25-36: Continue outreach and enrollment, compile final report and outcomes evaluation

**Community Health Worker Training**
- Semiannual training events
Racial Equity
As described throughout this proposal, through our executive leadership, boards, committees, and strategic focus ADA is committed to racial equity to achieve our mission to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

Minority Participation
Our intent is to target our Community Grants Program to engage with not-for-profit entities majorly controlled and managed by minorities in the targeted geographic areas. Our DPP program and CHW training will also focus on minority health coaches and CHWs who reside and care for their communities.

Jobs
ADA’s health transformation collaborative model is committed to creating sustainable jobs in the Chicago region. Our Diabetes INSIDE program will hire a Chicago-area practice coach and coordinator to oversee this important work. Our DPP program will also hire a coordinator in Chicago, and support additional health coaches who reside in underserved communities. Our Community Grants Program will directly fund minority-led organizations to support their operational and hiring capacity. More detail on these positions is described in our attached budget.

Sustainability
Health transformation collaboratives represent the future of building an equitable healthcare system for all Americans. ADA is strategically focused to build and sustains these collaboratives over the long term. ADA is a trusted convener, and our focused mission, domain expertise and public trust allow us to lead a national, long-term collaboration of healthcare stakeholders to improve diabetes prevention and management. ADA is uniquely positioned to act as a backbone organization by responsibly and transparently facilitating a national, multi-sector campaign to improve diabetes population health.

We will leverage our regional and national business development teams to work with the following market sectors to sustain these important efforts.

Government
Government plays a crucial role in defining and implementing policy to improve the health of our citizens. ADA works with local, state and federal agencies to advocate on behalf of patients, promote research, and support the important work of the Department of Health and Human Services, the Department of Veterans Affairs, state and local health departments, and policymakers at all levels of government.

Industry
The pharmaceutical, biotech and health information technology sectors drive innovation in health care and provide crucial products and services for people with diabetes. Diabetes INSIDE supports the acceleration of evidence-based innovations and market-based solutions by working with industry to steward meaningful and socially responsible change at all levels of the health care ecosystem.

Employers
Nearly 50% of all U.S. citizens receive their health benefits from their employer. In 2017, diabetes accounted for $237 billion in direct medical costs and $90 billion in lost productivity. Employers who
provide health insurance to their workers have both a moral and fiduciary responsibility to support diabetes population health initiatives to reduce this unsustainable social and economic burden. *Diabetes INSIDE* works with employers to improve their wellness programs, health benefits plan design and interactions with health systems through data sharing and active participation in healthcare quality improvement initiatives.

**Commercial Payers**
Strong health insurance markets are vital to a healthy nation. *Diabetes INSIDE* works to catalyze the shift from fee-for-service to value-based care and provides a fertile environment for innovative payment models and novel payer services to accelerate change in regional health markets.

**Nonprofits and Philanthropic Organizations**
Many nonprofits are working to improve population health at all levels of the ecosystem. *Diabetes INSIDE* identifies and supports these organizations by accelerating their efforts, amplify existing work and streamline duplicative efforts. By working together, ADA and other nonprofits have a much greater collective impact on diabetes population health while breaking down siloes and barriers to collaboration and transparency.

**Governance Structure**
ADA health transformation programs are structured to responsibly allocate resources based on rigorous milestones and contracting. We have internal controls and policies in place for the administration and management or our award. Each award is also given an identification number to track separately its activity and to avoid comingling its funds with the funds of other awards. Our data collection and sharing protocols meet all state and federal requirements for healthcare privacy, and our deep experience with funding research and receiving state and federal funding to advance our mission position us well to be good business stewards.
Racial Equity Impact Assessment Guide

IDENTIFYING STAKEHOLDERS
Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal/policy?
The mission of the American Diabetes Association (ADA) is to prevent and cure diabetes and improve the lives of all people affected by diabetes. Our proposed healthcare transformation collaborative will benefit all people affected by this disease but will strategically focus on the African American and Hispanic/Latino populations in underserved communities in Chicago.

ENGAGING STAKEHOLDERS
Have stakeholders from different racial/ethnic groups especially those most adversely affected—been informed, meaningfully involved and authentically represented in the development of this proposal? Who’s missing and how can they be engaged?
ADA’s executive leadership and staff, network of Diabetes Advocates, healthcare professionals, national and local boards and committees, support and publication of scientific research well represent the racial and ethnic groups we hope to support through our healthcare transformation collaborative. If we are awarded funds from the Illinois Department of Healthcare and Family Services, we will directly engage with minority-led community organizations and public health experts throughout Chicago to better position our interventions to meet their needs.

IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES
Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?
ADA both funds research in and publishes quantitative and qualitative evidence extensively on racial inequities through our peer-reviewed journals. A recent and comprehensive study convened by ADA and led by our former board president Dr. Felicia Hill-Briggs reviews in rigorous detail the many challenges and variables that lead to these inequities, and our healthcare transformation collaborative leverages this and other evidence to guide the design and deployment of our interventions to ensure efficacy, equitability and sustainability.

EXAMINING THE CAUSES
What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?
The causes of racial inequities in diabetes prevalence and outcomes are myriad and challenging. Socioeconomic status and social determinants of health – complex constructs which include economic stability, education, housing, food environment, healthcare access and community context – are driving factors that impact racial and ethnic minorities negatively compared to their white peers. Our proposal takes a wholistic approach to addressing these challenges by both training and resourcing the professionals who work to tackle these barriers and by better coordinating the health delivery and public health system services designed to overcome them.

CLARIFYING THE PURPOSE

What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

As a society, we have the tools and resources to help all people with or at risk of diabetes thrive. Unfortunately, new, effective evidence-based interventions and innovations are slow to get to those who might benefit. Our health delivery systems remain fragmented despite the evidence for team-based care, preventive strategies and community health approaches. These trends ultimately lead to health disparities in diabetes prevention and management and their staggering societal impact.

Our proposal aims to reduce these disparities by ensuring that people get the right care at the right time regardless of their zip code or skin color. Our interventions are designed to systematically improve the consistency of care delivery at both the health system and community health level using improvement methodologies and rigorous data collection and analysis that continually measures impact and advances change.

CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

ADA sees little risk for adverse impacts of a policy that resources health transformation collaboratives. Positive changes that result from this initiative can be studied and mirrored in communities across America to benefit all people of all racial and ethnic backgrounds with or at risk of developing diabetes, and ADA hopes to work closely with the state of Illinois to learn together and disseminate successful and impactful approaches.

ADVANCING EQUITABLE IMPACTS

What positive impacts on equity and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

By ensuring that health delivery systems have the resources, training, and data to improve quality we are confident our proposal will meaningfully advance equitable care for African Americans and Hispanic/Latino communities in Chicago. All healthcare stakeholders can do more and ADA constantly engages with industry, government, payers, non-profits, and employers to maximize future impacts.

EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

ADA hopes to work with the Illinois Department of Healthcare and Family Services to identify best practices that advance racial equity. Our proposal is designed to systematically identify gaps and address barriers to equitable care through proven improvement methodologies and data science. Working together, we can identify better ways to reduce racial disparities and use the data we glean from this opportunity to advance our shared goals toward health equity.

ENSURING VIABILITY AND SUSTAINABILITY

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

ADA’s proposed healthcare transformation collaborative is based on well-established and effective interventions that are proven, published, and endorsed by the healthcare community. Our Diabetes INSIDE® initiative, CDC Diabetes Prevention Program work, Community Grants Program and Community Health Worker engagement efforts have track records of success in producing improved
health outcomes, fiduciary responsibility, publications, and accountability. We have attached several publications and links to our body of work with this grant proposal and welcome discussions, questions and feedback from the Illinois Department of Healthcare and Family Services toward ensuring a vibrant, sustainable collaborative.

IDENTIFYING SUCCESS INDICATORS
What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Our overarching goal is to prevent progression to diabetes and improve outcomes for people with existing diabetes in underserved communities in the Greater Chicago region. Our proposed series of interventions will build a robust data collection and reporting infrastructure to evaluate against these aims. Our experience with population health data management and community health outcomes reporting uniquely positions ADA to document and evaluate long-term regional impact.