POSTER PRESENTATION GUIDE

COMMUNITY HEALTH INSTITUTE & EXPO 2017
MANCHESTER GRAND HYATT SAN DIEGO, CA AUGUST 25-29
The National Association of Community Health Centers (NACHC) is the leading national advocacy organization for Community Health Centers and the more than 25 million patients they serve. Membership is open to health centers, professionals, non-profits, corporations, and students. Our members make us stronger. Join the movement!

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JOIN TODAY!

National Association of Community Health Centers
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The Community Health Institute (CHI) & EXPO is the ideal place to learn about current health center research activities and innovations. The 2017 Poster Presentations provide a unique opportunity to exchange ideas, problem-solve, and network with colleagues. Discover the results of innovative research initiatives and enjoy the opportunity to ask in-depth questions.

To provide ample time for poster review, the 2017 Poster Presentations are scheduled for both Sunday and Monday during the CHI. Presenter attendance is required for Sunday, and strongly encouraged for Monday’s presentations.

**2017 NACHC Poster Presentation Awards**

There are 73 posters, including 14 A.T. Still University-School of Osteopathic Medicine posters, to be presented during the 2017 poster session. This year, Best in Show posters will be chosen by YOU! Vote for your favorite Research and Innovation posters on the mobile app, by clicking on Vote for the Best Posters, or complete a Poster Voting Card which can be obtained at the NACHC Booth in the Seaport Foyer. When judging poster presentations, please consider the following criteria: innovation of information, presentation of poster, relevance of topic, impact of findings, replicability of best practice, and value of information to other health centers.

All poster voting MUST be completed by 3:00pm on Monday, August 28.

If voting by the Mobile App, refer to the conference program for instructions on downloading the app.

If voting by Poster Voting Card, you MUST submit your completed card at the NACHC Booth in the Seaport Foyer.

All 2017 Poster Presentation winners will be announced during Tuesday’s General Session.

Prizes will be awarded to the TOP three winners in each category of Research and Innovation:

- **First Place:** $250 AND a Complimentary Registration to the 2018 CHI & EXPO in Orlando!
- **Second Place:** $150
- **Third Place:** $100

**Fill-in-the-Blank Poster Scavenger Hunt Contest**

Don’t miss out on all the great innovations presented during the poster sessions at the CHI! While you’re there, make sure to participate in the Fill-in-the-Blank Poster Scavenger Hunt to be entered into a random drawing for a $200 Amazon gift card. Simply drop by the NACHC Booth in the Seaport Foyer to pick up your scavenger hunt directions and fill-in-the-blank sheet. Then visit the poster presentations on Sunday, August 27 from 5:00pm - 6:30pm or Monday, August 28 from 12:30pm – 1:30pm in the Harbor Foyer to complete the scavenger hunt. Once you’ve filled-in all the blanks, turn the sheet back into the NACHC Booth with your name and contact information included to be entered in the random drawing. All scavenger hunt entries must be submitted to the NACHC Booth by 9:00am on Tuesday, August 29. Contest winners will be announced on Tuesday at 10:15am in the EXPO Hall located in the Seaport Ballroom. You MUST be present to win! (Refer to the conference program for contest rules.)

**A.T. Still University-School of Osteopathic Medicine**

This is the seventh graduating class of A.T. Still University-School of Osteopathic Medicine in Arizona (ATSU-SOMA), with a very high percentage of these graduates continuing their professional journey into primary care. NACHC and ATSU continue their partnership in the development of America’s primary care physicians through the university’s innovative model of medical education, linking osteopathic training to the nation’s community health centers. See these student and faculty posters, and become inspired by their commitment to community health and their vision of primary care delivery for the future.
**Poster Categories**

The poster presentations are categorized according to the following community health topics:

**A.T. Still University-School of Osteopathic Medicine in Arizona (ATSU-SOMA)**

**CP1** Evaluation of Patient-Provider Communication

**CP2** Bridging the Gap: Providing Health Education to Victims of Intimate Partner Violence

**CP3** Determining Efficacy of Dental Educational Interventions in Ohio Adolescents

**CP4** Using Resilience Training Curriculum in High School Students to Reduce the Consequences of Adversity

**CP5** SPROUT: A Qualitative Evaluation of a Nutrition-Based Intervention Encouraging Vegetable Consumption in Low-Income Populations Served in an FQHC

**CP6** Addressing Nutrition Education With Cultural Competence Using a Novel Approach: “My Traffic Light Plate”

**CP7** Addressing Individual Barriers to Physical Activity

**CP8** Evaluation of the Nutrition and Health Awareness Program and Changes in Physical Activity on Health and Wellness Education

**CP9** Evaluating the Impact of the Nutrition and Health Awareness Program on Physical Activity and Health Awareness

**CP10** The Mentors in Medicine Program: Improving Health Education in the Woodlake Community

**CP11** A Brief Intervention Model of Physical Therapy Within the Community Health Center


**CP13** 3D/4D Ultrasound Technology in Medically Underserved Communities: A Survey of Second-Year Medical Students

**CP14** When Family Medicine Residents Train in Community Health Centers, Do They Stay?

**Improving Care for Special Populations**

**CP15** Assessing Chinese Adolescent Risk Behavior at the Charles B. Wang Community Health Center

**CP16** Migrant Health Experience in Alamance County: Provider and Patient Perspectives on Innovation in Community-Based Healthcare

**CP17** Determining Best Practices for HCV Testing in Clinics With Predominately Hispanic Patient Populations Through Routine Screening of All Patients 13+

**CP18** The Impact of an Individualized Practice Unit on the Outcomes of Type 2 Diabetics

**CP19** Strategies to Improve Refugee Vaccination Records Access to U.S. Providers

**CP20** Improving Primary Care for LGBT People Through the Implementation of Sexual Orientation and Gender Identity Data Collection at FQHCs

**CP21** Innovative Approaches to Providing Essential Oral Health Services to Veterans

**CP22** Healing Hearts and Paws Program: Helping Veterans Learn to Recognize and Cope With PTS Issues Through Animal-Assisted Therapy

**Expanding Access to Care and Other Services**

**CP23** The Power of the First Phone Call: Factors Influencing Patients’ Likelihood to Return to a Medical Practice

**CP24** Developing Common Evaluation Measures to Sustain Community Health Worker Programs

**CP25** Not Just A Ride: Transportation Matters to Healthcare

**CP26** Reducing Emergency Department Visits by Behavioral Health Patients Using an Integrated Health Clinic

**CP27** Improvements in Community Health Center Accessibility for Low-Income, Non-Elderly Adults in Three Southern States After Health Center Program Funding Increases

**CP28** The Impact of Pharmacist-Provided Spirometry Service on Access to Results in Primary Care Settings

**CP29** Emergency Department Diversion Liaisons Center Model Hub: Success and Lessons Learned

**CP30** Closing Gaps in Care: Emergency Department Follow-Up in the Outpatient Community Health Center Setting

**CP31** nccPA Health Foundation: Promoting Physician Assistants as Oral Healthcare Team Members

**CP32** HBV ECHO: Reducing Perinatal Transmission

**Patient and Community Engagement**

**CP33** Engaging Community Health Center Stakeholders to Reduce Health Disparities: An Increase in Knowledge and Health Literacy for Preterm Birth

**CP34** Elevating Patient Voices: Conducting and Disseminating Health Experiences Research in a Community Health Center Research Network

**CP35** Sharing Notes - An Avenue to Greater Patient Engagement: The OpenNotes Story

**CP36** Engaging Patients as Partners in Managing Hypertension Through Home Blood Pressure Monitoring

**CP37** Recruitment Strategies Among Diverse, Low-Income Patients With Chronic Disease at a Community Health Center
Public Health Crises
CP38 Opioid Review Committee: Implementing a Controlled Substance Policy and Clinic-Based Monitoring Program to Ensure Patient Safety and Provider Support
CP39 Innovation Across Sectors to Prevent Childhood Lead Poisoning
CP40 Austin Medical Center: A Public Health Collaborative in the Midst of an Unprecedented HIV Outbreak Due to Intravenous Substance Abuse
CP41 Improving Access to Naloxone – Community Health Worker-Led Opioid Overdose Prevention Program in Bronx, New York
CP42 Using Project ECHO to Combat the Opioid Epidemic With an Integrated Approach to Patient Care

Quality of Care and Quality Improvement
CP43 Improving Access to Care for Patients With Hepatitis C in Primary Care
CP44 Effect of Mailing FIT Tests Directly to Patients on Provider Colorectal Cancer Screening Rates
CP45 Integration of Clinical Pharmacy Services in a Federally Qualified Health Center
CP46 Tobacco Intervention in Primary Care Treatment Opportunities for Providers
CP47 A Team-Based Care Approach for Improving Colorectal Cancer Screening Rates at a Federally Qualified Health Center
CP48 The Navigational Health Visit and Its Role in Population Management at Albany Area Primary Health Care
CP49 Mountain Comprehensive Health Corporation: Making a Difference in Diabetes Control
CP50 Bringing Community Partners Together to Address Unspoken Realities of Chronic Disease, Diabetes, and Food Insecurity
CP51 Linking Clinical Care With Community Supports
CP52 Integration of a Home Blood Pressure Monitoring Program in Hypertension Management at a Community Health Center

Social Determinants of Health
CP53 Assessing Food Insecurity in the West Side Neighborhood of Chicago
CP54 Addressing Patients’ Social and Economic Needs in Medical Care Settings: A Systematic Review of the Literature
CP55 Understanding the Community-Level Social Determinants of Health of Community Health Center Patients
CP56 Creating a Social Needs Program in a Federally Qualified Neighborhood Health Center
CP57 La Clínica’s Transitions Clinic: A Comprehensive Clinic Serving the Health and Psychosocial Needs of the Re-Entry Population
CP58 Building Hospital-Community Partnerships to Reduce Smoking: Challenges and Opportunities
CP59 Multi-Sector Strategies to RAISE Community Health
CP60 The Community-Centered Health Home Model: Mobilizing Health Centers to Improve Community Determinants
CP61 Integrating Civil Legal Aid Into Nurse-Managed Health Centers

Technological Solutions and Tools to Improve Care and Population Health Management
CP62 Leveraging HIT for Evidence-Based Pediatric BP Management in the Safety Net
CP63 Using Population Managers to Increase Screening Rates for Breast, Cervical, and Colorectal Cancer in a Southwest Georgia FQHC
CP64 A Further Look at Health Information Technology Tools to Facilitate Health Insurance Support
CP65 Project ECHO Complex Care Management: Using Technology to Support Primary Care Nurses
CP66 Data-Driven, Team-Based Care Strategies to Improve Chronic Disease and Preventive Care Outcomes in FQHCs
CP67 Community Vital Signs: Using Neighborhood-Level Data for Research, Care Delivery, and Population Health Management

Workforce
CP68 Current Family Medicine Residents’ Views of Community Health Centers as a Site for Employment
CP69 Ten-Year History of Postgraduate Nurse Practitioner Residency and Fellowship Training Programs: Challenges, Opportunities, and Outcomes
CP70 The Community Health Center Track: A Novel Third-Year Clerkship Track
CP71 Joint Venture Health: A Health Center-University Partnership to Support Workforce Development and Team-Based Care
CP72 The Development of a Provider Onboarding Program: Preparing New Graduate Advanced Practice Providers for Practice in FQHCs — WITHDRAWN
CP73 From Inception to Accreditation: Developing a Postdoctoral Psychology Residency in an Integrated Care FQHC Patient-Centered Medical Home
Blackbaud is pleased to support NACHC and the endeavors of those health center professionals, as well as students, who have submitted their best practice posters for the 2017 Community Health Institute & EXPO Poster Presentations.

We are proud to partner with NACHC as an organization that is committed to outstanding public service in the provision of affordable, quality health care to more than 20 million Americans.

**About Blackbaud Inc.**

Leading uniquely at the intersection point of technology and social good, Blackbaud provides software services, expertise, and data intelligence that empowers and connects people to advance the social good movement. We serve nonprofits, healthcare organizations, foundations, corporations, education institutions, and the individual change agents who support them.

**Financial Edge NXT**

The Financial Edge NXT is Blackbaud’s integrated nonprofit management solution designed to help nonprofits save time, improve accuracy, and ensure accountability. Built on more than three decades of ideas and best practices, Financial Edge NXT delivers a comprehensive cloud fund accounting solution so health organizations can save time on data entry and reporting while demonstrating effective stewardship—all while making better strategic decisions with your data.

Community health providers are facing greater internal and external pressures to demonstrate fiscal responsibility and expand their services. This need for increased transparency coupled with ever-evolving regulatory requirements means it’s more important than ever for nonprofits to be equipped with comprehensive tools to record, analyze, and understand all of their financial data.

Whether you’re a hospital system, medical research facility or health-cause related organization – raising support and awareness for health systems and health-causes as well as building and maintaining a loyal, engaged community is critical to your mission success. You also face further demands to raise more funds despite economic uncertainty, rising costs and limited resources. Blackbaud’s healthcare fundraising software, marketing and management resources can help!

**How the Financial Edge NXT Impacts Community Health Centers**

On average:

- Cloud-based, managed deployment saves 40 hours a year on IT
- 25% less staff for audit work
- Financial staff productivity: Reporting functionality can save 15–20 hours a month. Also, budgeting with the Financial Edge NXT can save 64 hours per year

“The ability of staff to develop multiple report styles has enhanced our productivity, specifically with the reporting needs of healthcare organizations like us. The ability to manipulate any report, any way we want makes Financial Edge unmatched in the industry.”

– Russ Dubuc, CFO, Community Health Systems
CP1

**Evaluation of Patient-Provider Communication**

**Poster Type:** Research  
**Category:** Behavioral Health Services

**Research Objectives:** Patient understanding of health instructions is essential to treatment outcomes because it affects the patient’s motivation and ability to make informed health decisions. With this in mind, this project aimed to quantify patient retention of medical instructions to determine the patient’s and provider’s perception of the patient’s retention.

**Study Design/Methods:** Investigators were medical students who observed medical appointments as part of their regular duties and recorded the health instructions given to the patient. After the appointment, a survey was administered to the patient that included questions regarding demographics, instructions, and perceived understanding of the instructions. The provider was also given a survey that assessed their perception of the patient’s retention of instructions using a semantic differential. Participants were North Country HealthCare patients who were 18 and older, spoke English as a first language, and had no memory deficits. Categorical data were collected and are to be analyzed by a biostatistician.

**Principal Findings and Quantitative/Qualitative Results:** Data were collected using Google forms. The data will be analyzed to show how well patients retained the health instructions given to them by the provider. The data will also demonstrate how the patient’s and provider’s perception of understanding correlates with actual understanding. Out of 76 patients approached, 74 participated in the study. Out of nine providers approached, eight participated. Data analysis will be completed by April 2017.

**Conclusions on Impact on Health Centers:** This project aimed to gather insight about the health information retained within a patient-provider interaction. This relationship had not previously been examined at this location. Findings from the study will be used to identify relationships between patients’ retention of medical information and perceptions of retention held by both the patient and their provider, and will be presented at a future date to stakeholders, provider participants. Future research should expand to include patients who do not speak English as a first language and patient caregivers.

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**Presenter(s):** Karla Sanchez, Hillary Park

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CP2

**Bridging the Gap: Providing Health Education to Victims of Intimate Partner Violence**

**Poster Type:** Research  
**Category:** Improving Care for Special Populations; Patient and Community Engagement; Public Health Crises; Quality of Care and Quality Improvement; Social Determinants of Health

**Research Objectives:** Intimate Partner Violence (IPV) leads to consequences manifesting as adverse health outcomes, seen especially in underserved populations such as Brooklyn, New York. It is therefore integral that victims of IPV seek healthcare. This project aims to help bridge the gap between victims of abuse and the healthcare system.

**Study Design/Methods:** Female participants were recruited from The Healing Center, a Brooklyn sanctuary for women and children. Participants were English and/or Spanish-speaking adult victims of IPV. Over a one-hour session, participants were individually shown eight brief educational videos encompassing advice and information regarding various IPV topics. Post-intervention, an investigator performed a personal debrief interview with each client that included demographic information, prior/current relationship information, and module feedback in the form of open-ended questions. Responses were analyzed to identify recurrent themes, strengths and areas of improvement, and strong positive or negative opinions of the intervention.

**Principal Findings and Quantitative/Qualitative Results:** All ten current clients of The Healing Center agreed to participate in our project. Debrief interviews will be conducted promptly after each participant views the modules. We anticipate a 100% response rate to our interview. Through their interview responses, we will evaluate how receptive participants were to the material, as well as their intention to apply the information toward their individual situations. Due to the sensitive nature of this topic, it is imperative that our clients can meet when they are most likely to be safe and receptive to our intervention. Data will be collected and recorded by April 2017.
Conclusions on Impact on Health Centers: By empowering participants with knowledge of the importance of their physical and mental health, they will hopefully pursue continuity of care and build relationships with healthcare providers. Participant feedback will help us better tailor our modules to the needs of our clientele and the IPV community. In the future, we aim to assess long-term retention of healthcare material and expand our reach to a wider audience in Family Health Centers at NYU Langone.

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Presenter(s): Grace Chang, Daniel Sidhom, Andrew Kim, Neil Bhutwala

CP3
Determining Efficacy of Dental Educational Interventions in Ohio Adolescents

Poster Type: Research

Category: Improving Care for Special Populations

Research Objectives: We are evaluating what the effect of a combined interactive and passive learning experience has upon general dental health knowledge and interest in the Smile Program among sixth grade students, at a Clermont County, Ohio middle school, to aid in understanding poor dental health in rural Appalachian middle school aged children.

Study Design/Methods: The intervention consisted of two educational sessions presented to sixth graders in Clermont County. The first session consisted of a presentation on oral health and the Smile Program, a free dental care program. The second session, was a brief review of the first session. Students then created posters using information from the first session. Identical surveys were administered at the beginning of the first session and at the end of the second session to determine change in knowledge on oral health and the Smile Program. Individual surveys will be compared through a unique ID created by each student.

Principal Findings and Quantitative/Qualitative Results: Results will be analyzed by comparing the pre- and post-surveys of each individual student using their unique ID. There are 110 students, 87 students completed the pre-survey and 63 students completed the post-survey. A change in knowledge of oral health and the Smile Program will be determined by comparing answers to the pre-post surveys. Statistical analysis will be applied to determine what degree the general health knowledge and interest in the Smile Program changed within the student population. Analysis will be completed by April 2017.

Conclusions on Impact on Health Centers: Once data have been analyzed, baseline knowledge of dental health and interest in the Smile Program can be assessed. We will assess if the educational intervention changed students’ knowledge on dental care and interest in the Smile Program. Results of this analysis will be provided to the school administrators and HealthSource. Another study replicating our methods would help to determine if the intervention was successful. Successful or not, it would allow further insight regarding educating children to enhance dental health. Every aspect of the project could be replicated in a different middle school or age group.

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Presenter(s): Ashley Mohan, Shruthishree Sukumar, Esther Kim, Kathryn Lafaans

CP4
Using Resilience Training Curriculum in High School Students to Reduce the Consequences of Adversity

Poster Type: Research

Category: Patient and Community Engagement; Social Determinants of Health

Research Objectives: Adverse childhood experiences (ACEs) have been linked to adverse health, behavioral, and academic outcomes. Resilience has been shown to ameliorate these outcomes. This study practiced implementing a resilience-building curriculum, examining curriculum efficacy at raising perceived resilience, and elucidating the relationship between academic performance and change in self-perceived resilience.

Study Design/Methods: The resilience curriculum utilized multiple activities addressing values, emotions, positive thinking, reality checks, everyday courage, and role models. It was delivered over three, non-consecutive days by three teams of medical students to 118 high school students. Identical, 10-question surveys were given before (pre) and after (post) the curriculum to assess self-perceived resilience. A subsequent teacher survey recorded grade point average (GPA) and school attendance for each student. Measures of resilience included social support, self-confidence, stress management, perception of school performance, and optimism about the future. Data were analyzed using the Mann-Whitney Wilcoxon test, Cronbach’s alpha score, and generalized linear models.
Principal Findings and Quantitative/Qualitative Results: Of the 118 high school participants, 115 (97%) pre- and 87 (73%) post-surveys were collected for a total of 77 complete data sets. A high Cronbach’s alpha score (0.84) shows that Mean Resilience Score (MRS) can be an accurate measure of students’ average resilience scores. Data analysis of the surveys showed that the curriculum was not significantly effective in changing short-term MRS (p > 0.05). Students with a GPA above 3.0 showed higher baseline MRS in both pre and post when compared to students with a GPA below 3.0 (GPA 3.0-3.5: p=0.0289 3.5: p=0.0370 < 0.5).

Conclusions on Impact on Health Centers: The resilience curriculum was not shown to significantly alter students’ MRS. However there was a significant association between students with higher GPAs and higher MRS when compared to students with lower GPAs. Future studies can investigate the association between GPA and resilience and add follow-up assessments. Positive feedback was received from students and the health teacher, who plans to incorporate aspects of the curriculum going forward. As part of community-wide prevention, the curriculum shows how building resilience can be a tool to intervene and prevent consequences of ACEs. Results will be shared with local providers and educators for their consideration.

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Presenter(s): Benjamin Berthet

CP5
SPROUT: A Qualitative Evaluation of a Nutrition-Based Intervention Encouraging Vegetable Consumption in Low-Income Populations Served in an FQHC

Poster Type: Research
Category: Patient and Community Engagement; Public Health Crises; Social Determinants of Health

Research Objectives: Nutrition is integral in preventing major health concerns such as obesity, diabetes, and coronary artery disease. These conditions give King County residents a 10-year lower life expectancy compared to Washingtonians in other counties. The SPROUT Program was designed to assess the impact of a waiting room intervention on dietary practices.

Study Design/Methods: Thirty-five patients from HealthPoint Midway Clinic were recruited from the waiting room to participate in an intervention which was repeated on three separate days. Each participant completed a pre-intervention survey assessing qualitative and quantitative data relating to dietary practices. Following the survey, participants received one-on-one educational presentations from a medical student and take-home packets containing nutrition information. A sampling of healthy food options was available to participants during the intervention. A telephone follow-up survey was administered seven weeks (4/10 – 4/12) post-intervention to assess how the educational intervention impacted dietary practices.

Principal Findings and Quantitative/Qualitative Results: Qualitative and quantitative data have been collected from the pre-intervention surveys (n=32). The follow-up telephone survey data which will be collected two months post-intervention, on 4/20/2017, will be compared to pre-intervention data to assess for change in dietary practices. The principle finding will be the change in reported number of meals containing vegetables. It is hypothesized that there will be an increase in number of meals containing vegetables among participants.

Conclusions on Impact on Health Centers: Waiting room interventions are an innovative and effective way of delivering educational information in a time efficient and impactful manner. This is an important vehicle for delivery of education when providers lack time during clinic visits to discuss nutrition and can be applicable to other educational health topics as well.

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Presenter(s): Daniel Nassar

CP6
Addressing Nutrition Education With Cultural Competence Using a Novel Approach: “My Traffic Light Plate”

Poster Type: Research
Category: Patient and Community Engagement

Research Objectives: One of the growing concerns of obesity in the Sunset Park Brooklyn, NY, community is due to limited nutritional health literacy. To address this concern, we sought to find an improved and culturally competent way to present nutrition information at clinics for the diverse Hispanic, Chinese, and Caribbean American communities.

Study Design/Methods: We designed “My Traffic Light Plate” as a culturally competent booklet that integrates the MyPlate nutrition guide with culturally specific foods organized into Red, Yellow, and Green categories based on their nutritional value. We will evaluate the booklet’s effectiveness on nutrition education utilizing the Stage of Change (SOC) theory to assess participant’s likelihood to improve their diet. This two-week study involves one 20-minute individual education session with investigators, a one-week follow-up phone call, and survey distribution at both encounters. Participants must be members of the Family Health Centers at NYU Langone. Qualitative data of participant’s SOC will be collected from the surveys.

Principal Findings and Quantitative/Qualitative Results: We aim to recruit a total of 120 participants for the study. We anticipate our findings to show differences in participant’s Stage of Change (SOC) post-intervention. Three of the five stages of SOC will be measured in the pre- and post-
surveys: “Precontemplation, Contemplation, and Action.” We hypothesize that the “My Traffic Light Plate” booklet will encourage participants to advance from “Precontemplation” to “Contemplation” or to “Action.” This progression will reflect an active approach towards improving their diet. We also hypothesize participant’s perception of their understanding of healthy nutrition to increase. Parameters will be evaluated via survey responses.

Conclusions on Impact on Health Centers: We hypothesized that nutrition knowledge can be greatly improved through methods that address cultural competency and health literacy. The “My Traffic Light Plate” booklet is designed to be simplistic and user-friendly for people of all ethnic, educational, and socioeconomic backgrounds. The study is currently under IRB review and will begin shortly thereafter. Upon completion of study and successful results, we intend to formally introduce the booklet to nutritionists and physicians at all the clinics. Consideration for future research should include a longitudinal study evaluating the long-term maintenance of healthy nutrition through the use of the “My Traffic Light Plate” booklet.

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Presenter(s): Samantha Ho, Pragya Kalla, Mark Chang, Blessen George, Eric Eck

CP8
Evaluation of the Nutrition and Health Awareness Program and Changes in Physical Activity on Health and Wellness Education

Poster Type: Research

Category: Behavioral Health Services; Improving Care for Special Populations; Patient and Community Engagement; Public Health Crises

Research Objectives: To identify the overall improvement in physical activity, health and wellness education, and health attitudes among 7-12 year old children as a result of implementing the NHA (Nutrition and Health Awareness) program and the use of the Sqords™ brand accelerometers in order to combat rising pediatric obesity and related diseases.

Study Design/Methods: This pilot study recruited 28 participants, children of El Rio Community Health Center staff, ages 7-12, to attend an education health fair teaching physical activity, food groups, reading nutrition labels, diabetes, and cardiovascular disease. Sqords™ activity accelerometers were provided to participants to continually monitor their level of physical activity. Five weeks of data was collected (one week prior and four weeks after a health fair) and was analyzed to determine the most common barriers and current physical activity. Post-survey data used a Z-test to show changes in intent to exercise and tips reported to be most helpful.

Principal Findings and Quantitative/Qualitative Results: Of the 135 people who completed the pre-survey, 58 people (43%) met the inclusion criteria and participated in the intervention. The null hypothesis was 50% of participants would not have an altered intent to engage in physical activity. Post-intervention, 100% of the participants wanted to exercise more, while 98% of the participants intended to exercise more (P value < 0.01). The most helpful solutions offered were splitting physical activity into 10-minute increments, exercising at home and walking around a mall/grocery store. The most commonly perceived barriers were weather, lack of motivation, safety, and energy.

Conclusions on Impact on Health Centers: Our study helps elucidate the most prevalent obstacles faced by Chicago CHC populations when trying to exercise and also solutions that community members found helpful to overcome these barriers. These findings will be shared with CHC physicians and nutritionists to assist them in motivating patients to increase their daily exercise. Increasing the level of patient physical activity may help improve chronic disease states and decrease stress in this population. Future research would include assessing the effectiveness of the most helpful solutions, identifying which aspect of the intervention had the biggest impact on increasing intent to exercise, and long-term participant follow-up.

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Presenter(s): Meagan Johnson
evaluate physical activity continuity. Additionally, statistical analysis compared health attitudes and understanding of nutrition and health prevention by comparing pre- and post-questionnaires from the health fair.

**Principal Findings and Quantitative/Qualitative Results:** A paired t-test compared scores of the pre- and the post-intervention health and wellness questionnaire (15 questions) on material taught in the health fair: response rate = 100%, a significant difference (p-value=0.0007) existed in questionnaire scores between the pre-intervention (M=9.857, SD=3.33, 95% CI=8.79, 10.93) and post-intervention (M=11.786, SD=2.9, 95% CI=10.56, 13.02) results. Results suggest intervention is positively correlated to improvements in health knowledge (20% increase in questionnaire scores); 18% of children (71% of sedentary children) increased planned amount of exercising per day according to pre- and post-survey. Sqord™ activity data was insignificant (p=0.6).

**Conclusions on Impact on Health Centers:** Preliminary analysis of the pre- and post-questionnaires suggests the NHA program is positively correlated with improvement in health knowledge. The increase in children’s planned exercise amount indicates a correlation of the NHA program and positive change in health attitude. Sqord™ activity data was insignificant. Future research can involve: addressing parental involvement on childhood health, modified age range of participants, and questionnaire. The project had a positive impact on the health center, bringing health awareness to early aged children. There are plans to present this research to the health center, and the health center plans on continuing the intervention.

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**Presenter(s):** Sameeha Khalid, Suneun Kim, Muhammad Ulhaque, Shovna Mishra

**CP9**

**Evaluating the Impact of the Nutrition and Health Awareness Program on Physical Activity and Health Awareness**

**Poster Type:** Research

**Category:** Patient and Community Engagement; Public Health Crises

**Research Objectives:** The Centers for Disease Control and Prevention report that one-third of children ages 6-17 exercise 60 minutes daily. Inactivity is a known risk factor for obesity and chronic disease. The “Nutrition and Health Awareness” (NHA) program teaches children basic health and nutrition concepts and benefits of physical activity.

**Study Design/Methods:** A five-week curriculum on health, nutrition, and exercise concepts was presented to a fifth-grade class (N = 25) at a school in Gilbert, Arizona, identified through a community needs assessment. Activity levels and health awareness were measured prior to curriculum application. Physical activity was evaluated continuously for twelve weeks using Sqord™ accelerometers which allocate points based on activity intensity. Data was analyzed with a repeated measures ANOVA to determine significance of changes in activity. Health awareness and attitudes were evaluated at weeks zero, six, and twelve using an NHA curriculum-based questionnaire; data was analyzed with a paired t-test.

**Principal Findings and Quantitative/Qualitative Results:** There was a significant increase in physical activity from the pre-educational baseline each week, except for the week after the fifth lesson (during the school’s spring break). De-identified NHA questionnaires showed a statistically significant increase in class average scores from 66.03% (60.48-71.58) to 83.49% (77.95-89.03), 95% CI, p<0.001 which was obtained by individually comparing the results, pre- and post-program. There were 25 questionnaires delivered; 21 (84% response rate) were completed at week 0 compared to 25 (100% response rate) at week 6. Twelve-week assessments will be completed April 27, 2017.

**Conclusions on Impact on Health Centers:** An overall increase in physical activity and health awareness was observed from data analysis. Significant changes in activity and health awareness may be associated with use of the NHA program. This suggests that the NHA program may be applied in similar communities in an effort to improve health awareness and encourage lifelong health-seeking behaviors. Further studies that identify optimal target communities might expand the scope of the NHA program, and longitudinal studies might reveal its long-term impact. Such evidence could allow community health centers to offer the curriculum to patients in need of health and nutrition education.

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**CP10**

**The Mentors in Medicine Program: Improving Health Education in the Woodlake Community**

**Poster Type:** Research  
**Category:** Patient and Community Engagement; Social Determinants of Health

**Research Objectives:** Tulare County has an increased rate of childhood obesity compared to the rest of California and is associated with increased risks of chronic health conditions. Our program intended to teach students about preventative health topics and aimed to assess the effect of early health education on lifestyle choices.

**Study Design/Methods:** Each week four students from A.T. Still University-SOMA presented a 60-minute lesson to fifth graders. Pre- and post-quizzes were administered at each of the five lessons to record baseline knowledge and retention of information. Data analysis of the quizzes was performed using the paired t-test. After the final lesson, a self-assessment was administered to measure the student’s personal knowledge about health and application of the knowledge in their daily lives. The self-assessment was scored on a 5-point scale, 1 being strongly disagree and 5 being strongly agree.

**Principal Findings and Quantitative/Qualitative Results:**  
Eighty-six students were given surveys and 66 were completed (76.74% response rate, N=86, n=66). The average pre-quiz score was 4.18 out of 6 (SD = 1.21; n = 66). The average post-quiz score was 4.73 out of 6 (SD = 1.07; n = 66). Our P-value of <0.01 shows statistically significant improvement in post-quiz results from pre-quiz results, indicating improved health knowledge of students. The self-assessment questionnaire average score was 4.11 out of 5 (SD = 1.98; n = 15), indicating students generally agreed they could incorporate health knowledge gained from our modules into their lives.

**Conclusions on Impact on Health Centers:** Mentors in Medicine impacted our health center by connecting their resources to students and families. Our program demonstrated an improvement in student’s health awareness through our lessons and can be replicated as after-school enrichment through other health centers. We will present our work to our course directors and health center board. Future research may involve expanding the program to other grade levels and multivariate analyses regarding gender or ethnicity. Based on our work, we realized our program was positively correlated with short-term improvement in quantity of knowledge regarding health, safety, and exercise which may translate to improved lifestyle choices.

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**Presenter(s):** Harleen Sethi, Milad Bahrani, Tina Bui, Thanh Hoang, Jacob Moore, Omar Nagy, Jay Patel, Larry Wong

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**CP11**

**A Brief Intervention Model of Physical Therapy Within the Community Health Center**

**Poster Type:** Research  
**Category:** Quality of Care and Quality Improvement

**Research Objectives:** This case report will present data from two participants enrolled in an ongoing randomized controlled trial designed to investigate a brief intervention model of physical therapy (PT) for underserved persons in the community health care center (CHC) setting with low back pain (LBP).

**Study Design/Methods:** Participants are randomly assigned to an intervention or a waitlist control group. At session one, all participants complete the Brief Pain Inventory (BPI) and the Patient-Specific Functional Scale (PSFS). Intervention group participants receive instruction in a home exercise program and back healthcare education that includes elements of the brief intervention model. Wait-list control participants return in two weeks to receive exercise and back care instruction; these participants are called prior to the two-week visit to complete the BPI and PSFS. Follow-up phone calls are made at two, four, and eight weeks post-intervention.

**Principal Findings and Quantitative/Qualitative Results:**  
Scores on the BPI (pain severity and pain interference) and PSFS improved for participant A (intervention group) from baseline to two-weeks post-intervention, while scores for pain severity and the PSFS were worse from baseline to the end of the two-week waiting period for participant B (wait list group). Scores on the BPI and PSFS for participant A continued to improve at two, four, and eight-weeks post-intervention. Scores on the BPI and PSFS for participant B were better at two weeks post-intervention, but then regressed at four weeks and eight weeks post-intervention.

**Conclusions on Impact on Health Centers:** It has been our experience that individuals seeking care for LBP at a CHC have limited knowledge of back care and they often are only seen for one PT session. Our study found that pain and function improved in a person who received a session of PT using a brief intervention model of patient-centered exercise and back health education as compared to a person who waited two weeks to receive the intervention. Currently there is limited PT service provided in CHCs and a brief intervention model may be a way of providing quality care for persons with LBP at CHCs.

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**Presenter(s):** Cecelia Sartor-Glittenberg
**CP12**


**Poster Type:** Research  
**Category:** Social Determinants of Health

**Research Objectives:** The objective of our project was to provide elementary students with knowledge and skills regarding oral health, nutrition, and exercise so they are able to make informed decisions about their health. The purpose of this project is to educate and promote awareness on chronic disease prevention.

**Study Design/Methods:** OMS-II students taught three monthly 45-minute lessons on oral health, nutrition, and physical activity to 16 students in the combined third and fourth grade class at a charter school in an underserved community in Hawaii. After each lesson, 45-minute review sessions were held for two weeks to reinforce key points. Students completed pre-quiz questions before each session to quantitatively assess prior knowledge, as well as post-quiz questions to quantitatively measure retention of concepts. Students were also given Oral Care Calendars obtained from the American Dental Association website and pedometers to measure implementation of learned concepts in daily life.

**Principal Findings and Quantitative/Qualitative Results:** Participants include 17 students from a combined third and fourth grade class. Results from pre- and post-quiz questions are still being collected and will be analyzed to show any differences in average score. Students are recording four days worth of steps with pedometers, before and after physical activity lessons, so that we can monitor for change in activity levels. Lastly, we are collecting the Oral Care Calendars to monitor change in oral health habits.

**Conclusions on Impact on Health Centers:** Final data will show if students gained short-term knowledge from the Mini Doc curriculum and potential implementation in their daily routines. The project will be shared with the Waianae Comprehensive Community Health Center, the participating school, as well as other researchers. Health education at a young age is important for prevention of prevalent chronic diseases, and similar programs could be implemented at other community health centers by tailoring curricula to their specific communities using our project design as a potential resource.

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**Presenter(s):** Jenna Wong

**CP13**

3D/4D Ultrasound Technology in Medically Underserved Communities: A Survey of Second-Year Medical Students

**Poster Type:** Research  
**Primary Funding Source:** A.T. Still University Spark Tank Grant

**Category:** Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Public Health Crises; Quality of Care and Quality Improvement; Technological Solutions and Tools to Improve Care and Population Health Management

**Research Objectives:** The study explored medical student perception of perceived benefit using 3D/4D ultrasound technology in rural and medically underserved communities.

**Study Design/Methods:** Second-year medical students (N=147) learned 2D, 3D, and 4D ultrasound technology using the Fetus Ultrasound Examination Phantom for routine second trimester screening that contained a 23-week fetus (26 cm) in utero, and completed a survey about the usefulness of 3D/4D ultrasonography in rural healthcare. The survey asked about student perception of improving obstetrical care in medically underserved communities with the use of 3D/4D technology.

**Principal Findings and Quantitative/Qualitative Results:** The majority of students (99%) reported that the ultrasound was a useful tool to provide care for underserved populations, and 98% of students felt that ultrasound was a useful tool for patient education. Predicted use of ultrasound in future practice was positively correlated with believing access to ultrasound was useful in rural health care (r=0.32, p<.001) and would increase patient compliance (r=0.33, p<.001). Perceived proficiency of performing an ultrasound exam was positively correlated with believing access to 3D/4D ultrasound technology would increase patient compliance (r=0.17, p=.039).

**Conclusions on Impact on Health Centers:** Ultrasound technology is both safe and relatively inexpensive as a bedside imaging technology. Students felt access to 3D/4D ultrasound technology was particularly useful in rural healthcare and could be a valuable tool for patient education. Providing access to 3D/4D ultrasonography in a rural population could encourage seeking physician appointments and increase patient compliance.

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**Presenter(s):** Shannon McAllister, Seth McIntire
**CP14**

When Family Medicine Residents Train in Community Health Centers, Do They Stay?

**Poster Type:** Research  
**Category:** Workforce  

**Research Objectives:** The goal is to identify the number of family medicine residents in a CHC-based residency program who plan to seek employment in a CHC and the factors that have influenced their decision: (1) Are family residents considering employment in a CHC? (2) If yes, what factors have influenced their decision? If not, why?

**Study Design/Methods:** The Wright Center Family Medicine Residency program was created, in partnership with A. T. Still University-SOMA, to address the shortage of physicians in underserved areas trained to provide community-oriented primary care. The program is in six CHCs in six different states, and is the largest of its kind. In February 2016, residents were asked to complete a survey to determine if they were considering CHC employment after residency, and if yes, what factors influenced their decision. In February 2017, the survey was repeated with an additional question on influencing factors for not seeking employment.

**Principal Findings and Quantitative/Qualitative Results:** In 2016, 47 out of 58 residents completed the survey: 81% answered yes, they are considering CHC employment after residency, 15% said no, and 4% were unsure. The biggest factors that influenced their decision were: belief in CHC mission and fulfilling/rewarding work at 78% each; followed by familiarity with CHC practice setting at 68%. In 2017, 41 out of 51 residents completed the survey, with 73% answering yes for CHC employment, 7% no, and 20% unsure. The influencing factors were similar across both years.

**Conclusions on Impact on Health Centers:** Training family physicians in CHCs meets the health workforce needs of underserved communities and can be a cost-effective way to recruit and retain providers. Our results support the findings of Morris et al (2008) who found that CHC-trained physicians were four times more likely to work in a CHC than their non-CHC-trained counterparts. Both resident cohorts were strongly influenced by their belief in the CHC mission when considering employment options. CHCs should consider creating and/or expanding primary care residency programs as a strategy to meet their physician workforce needs.

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**Presenter(s):** Christine Morgan

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**CP15**

Assessing Chinese Adolescent Risk Behavior at the Charles B. Wang Community Health Center

**Poster Type:** Research  
**Category:** Behavioral Health Services; Improving Care for Special Populations; Social Determinants of Health  

**Research Objectives:** The CDC's Youth Risk Behavior Surveillance System (YRBSS) collects biennial data for youth health-risk behaviors; however, results for Asian subgroups are aggregated together, concealing intragroup differences. In order to better understand the culturally unique health risks faced by Chinese youth, this study will assess health-risk behaviors of Chinese adolescents.

**Study Design/Methods:** A 31-item modified version of the YRBSS survey will be administered by CBWCHC’s Teen Resource Center program to 100 patients aged 13-21 whose preferred language is Mandarin, Cantonese, or English. Behaviors investigated will include: behaviors that contribute to unintentional injury and violence; sexual behaviors related to unintended pregnancy and sexually transmitted infections; alcohol and other drug use; tobacco use; and inadequate physical activity. Analyses will include survey item frequencies, means, and 95% confidence intervals. Results from surveying CBWCHC Chinese adolescent patients will be compared to 2015 NYC YRBSS survey results for Asian adolescents.

**Principal Findings and Quantitative/Qualitative Results:** Data collection and analyses will take place between May and July 2017.

**Conclusions on Impact on Health Centers:** Health Centers will be able to use study findings to inform clinical practice and health education programming targeting Chinese youth.

**Author(s):** Matthew Chin, Research and Evaluation Associate, Charles B. Wang Community Health Center  
**Presenter(s):** Matthew Chin

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**CP16**

Migrant Health Experience in Alamance County: Provider and Patient Perspectives on Innovation in Community-Based Healthcare

**Poster Type:** Research  
**Primary Funding Source:** Elon University Lumen Prize  
**Category:** Improving Care for Special Populations  

**Research Objectives:** As non-urban communities across the United States become new migration destinations, healthcare providers must also adapt. Alamance County, located in North Carolina’s Piedmont region, is one such community. This
research seeks to better understand the ways in which small, community-based clinics are adapting to meet the needs of these increasingly diverse patients.

**Study Design/Methods:** This qualitative research compares the perspectives of providers and their patients at four small community-based FQHCs and volunteer-run clinics. We conducted 10 semi-structured interviews with community-based healthcare providers, and parallel focus groups (of 8-12 immigrant/migrant patient participants each), in four healthcare facilities in North Carolina's Piedmont region, a new migration destination, to see how the perspectives compare from provider to patient. These clinics included three FQHCs and one volunteer-run clinic. Interviews and focus groups were transcribed and coded for common themes using NVivo 10 software.

**Principal Findings and Quantitative/Qualitative Results:**
Data collection is ongoing, and will be completed by June 2017. Preliminary findings suggest that key themes emerging from this research include: the differences between institutionally-versus individually-driven innovation in healthcare practice; the reasons motivating patients to seek care at community-based clinics instead of emergency departments; and the role of translation services and other specific adaptive practices in guiding patient decision-making.

**Conclusions on Impact on Health Centers:** This research provides a unique opportunity to compare the perspectives of both healthcare providers and their patients, whose voices are not always heard, in North Carolina’s Piedmont region. With an increasingly diverse population, healthcare providers in this previously homogenous community must adapt their practices to ensure that their patient populations are receiving care to match their healthcare needs. Results from this research may help to inform future healthcare innovation in this region, and also provide insights to other communities across the United States experiencing similar demographic change.

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Presenter(s): Bethany Lake

**CP17**

**Determining Best Practices for HCV Testing in Clinics With Predominately Hispanic Patient Populations Through Routine Screening of All Patients 13+**

Poster Type: Research

Primary Funding Source: FOCUS Program funded by Gilead

Category: Improving Care for Special Populations

Research Objectives: The CDC recommends testing adults born 1945-1965 and at-risk populations for HCV (hepatitis C virus). However, Tiburcio Vasquez Health Center (TVHC) decided to screen all patients 13+ regardless of risk for 15 months to determine HCV prevalence and best practices based on our predominately Hispanic, low-income patient population.

**Study Design/Methods:** We updated our HCV testing protocol to test all patients 13 and older, regardless of reported risk to better identify overall HCV prevalence amongst our patient population. This was an opt-out protocol, which ensured that an HCV test would be included as part of standard of care at all TVHC clinics unless the patient chose to “opt-out.” We tracked all HCV tests performed on a monthly basis, as well as the number of HCV positive patients identified, by two categories--patients born inside the 1945-1965 birth cohort, and patients born outside the birth cohort.

**Principal Findings and Quantitative/Qualitative Results:**
After 15 months of routine screening (January 2016-March 2017) in all TVHC clinical settings, we observed significant HCV prevalence across our general patient population. We performed 6,130 tests in total, and identified 179 HCV antibody patients; 72 (40%) were born outside the 1945-1965 birth cohort. Of those 72 patients born outside the Baby Boomer birth cohort, 21 (29%) were born 1980 or later and 13 (62%) of those 21 patients born 1980 or later identify as “Hispanic.” Our youngest identified HCV ab+ patient was 15 years old, and our oldest HCV ab+ patient was 85, both Hispanic.

**Conclusions on Impact on Health Centers:** Broadening our HCV testing range to all patients 13+, regardless of reported risk, for a 15-month period proved effective for measuring our HCV ab reactive rates for both inside and outside the 1945-1965 birth cohort. While the CDC does recommend also screening high-risk populations, it can be extremely difficult for health professionals to assess all patients for risky behavior, especially in settings like TVHC with diverse and low-income patient populations. With 40% of our HCV ab+ identified outside the birth cohort, we have determined routine HCV screening for all patients 13+ is the best practice for our patient population.

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Presenter(s): Rachelle Bogue

**CP18**

**The Impact of an Individualized Practice Unit on the Outcomes of Type 2 Diabetics**

Poster Type: Research

Category: Improving Care for Special Populations

Research Objectives: The objective of this project is to determine whether the formation of an individualized practice unit (IPU) can lead to improved outcomes in type 2 diabetic patients, as measured by Hemoglobin A1C levels.

**Study Design/Methods:** Type 2 diabetic patients were assigned to one of two clinical diabetic groups, with a single nurse practitioner. The general clinic group would see the nurse
Many U.S.-bound refugees are vaccinated before arrival in the United States, and overseas vaccination records are available to U.S. clinicians through the Centers for Disease Control and Prevention’s (CDC) Electronic Disease Notification (EDN) system as well as on hard copies brought by the refugees. However, some refugee clinics may not review or have access to overseas vaccination records. Their lack of information may lead to indiscriminate overvaccination or unnecessary serologic testing, both of which consume scarce resources. Thus, successful integration of overseas vaccination records into clinic practice and immunization information systems (IIS) can improve refugee health and save resources.

**Description of Innovation:** We will provide background on the vaccination program for U.S.-bound refugees (VPR) and overseas-to-domestic vaccination information flow. Further, we will outline three strategies the CDC has initiated to improve provider access to vaccination records: (1) a five-state pilot project to link refugee health databases containing vaccination records with state IIS; (2) a pilot to link the EDN vaccination records directly to state IIS; and (3) enhancement of EDN user access. Lastly, we will share best practices garnered from implementation of these strategies.

**Impact or Result:** The benefits of this project are the following: refugee children and adult overseas and domestic vaccination records are available; vaccination records are timely and up-to-date; there should be reduced unnecessary vaccinations; there should be reduced missed opportunities; there should be improved public health understanding of completed vaccination rates in communities; and for some health centers, manual data entry into state IIS might not be necessary allowing for unnecessary loss in time.

**Replicating This Innovation:** All community health clinics who serve refugees can have access to overseas vaccination records through the CDC’s EDN system. The CDC will assess the success of the project in these 10 states and provide the next steps based on feasibility, capacity, and resources.

**Author(s):** Deborah Lee, MPH, Epidemiologist, Centers for Disease Control and Prevention

**Presenter(s):** Deborah Lee

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**CP19**

**Strategies to Improve Refugee Vaccination Records Access to U.S. Providers**

**Poster Type:** Innovation

**Category:** Improving Care for Special Populations; Quality of Care and Quality Improvement; Technological Solutions and Tools to Improve Care and Population Health Management

**Issue or Challenge:** Many U.S.-bound refugees are vaccinated before arrival in the United States, and overseas vaccination records are available to U.S. clinicians through the Centers for Disease Control and Prevention’s (CDC) Electronic Disease Notification (EDN) system as well as on hard copies brought by the refugees. However, some refugee clinics may not review or have access to overseas vaccination records. Their lack of information may lead to indiscriminate overvaccination or unnecessary serologic testing, both of which consume scarce resources. Thus, successful integration of overseas vaccination records into clinic practice and immunization information systems (IIS) can improve refugee health and save resources.

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**Author(s):** Deborah Lee, MPH, Epidemiologist, Centers for Disease Control and Prevention

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**CP20**

**Improving Primary Care for LGBT People Through the Implementation of Sexual Orientation and Gender Identity Data Collection at FQHCs**

**Poster Type:** Innovation

**Primary Funding Source:** Centers for Disease Control and Prevention

**Category:** Improving Care for Special Populations; Public Health Crises; Quality of Care and Quality Improvement

**Issue or Challenge:** Lesbian, gay, bisexual, and transgender (LGBT) people experience significant health and healthcare access disparities. Providers at FQHCs are unable to identify their LGBT patients in order to offer appropriate screening and treatment. Risk-based sexual health (RBSH) screenings are rarely completed, preventing patients from receiving appropriate screenings for sexually transmitted infections (STIs) and HIV. A bridge is needed between primary care and public health to address the needs of this population.

**Description of Innovation:** A cohort of 10 FQHCs in 9 states participated in a parallel intervention combining one year of
Impact or Result: The 10 FQHCs attended 14 quality improvement learning sessions, presented 55 cases at 23 Project ECHO LGBT videoconference learning sessions, and collected SOGI information in their Electronic Medical Record for 96,778 patients of 387 providers at 70 practice sites. A difference was observed in ease of SOGI and RBSH data collection for patients aged 13-18 versus patients 18+. The screening rates for the three STI/HIV measures increased as teams built the capacity to identify LGBT patients and provide them with appropriate screening and treatment. Through participation in the combined Project ECHO LGBT sessions and QI learning sessions, teams were able to make critical changes within their healthcare organizations to create LGBT-affirming environments. These changes include gender-neutral bathrooms, equality training during new hire orientation, and hiring of LGBT staff.

Replicating This Innovation: To replicate this innovation in other organizations, collection of SOGI and RBSH requires addressing culture first, data second. Support from leadership would be the critical first step. In order to make necessary changes with regard to process and protocol, the CEO and CMO of the organization would need to be on board and proactive in the implementation of this innovation. The implementation team would also need to have access to IT staff and an EMR specialist to provide appropriate input, critical EMR modification services, and management of SOGI, sexual healthcare, RBSH, and STD/HIV screening data. Partnerships with local organizations improve the success of this innovation through providing referrals for LGBT patients to the health center and providing materials or guidance specific to resources available in the geographic area of the organization.

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Presenter(s): Wanda Montalvo

CP21
Innovative Approaches to Providing Essential Oral Health Services to Veterans

Poster Type: Innovation

Category: Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement

Issue or Challenge: The Veteran Affairs Medical Centers (VAMCs) do not provide onsite dental services to veterans. Veterans need access to dental care within their communities. Some community health centers have identified veterans as a priority population for dental services and are implementing innovative ways to connect with veterans and provide them with much needed dental services. In certain cases, the Veterans Health Administration will provide reimbursement for dental services through direct provider agreements.

Description of Innovation: This poster will look at two different approaches to providing dental services to veterans. Zufalls Health Center in Dover, New Jersey uses its dental van and relationships with local VAMCs and Veteran Services Organizations (VSOs) to reach in-need veterans. Family Health Center of Marshfield uses its unique relationships with the local VA to provide dental services to Veterans.

Impact or Result: Dental services were provided to veterans within their communities and in some cases veterans chose to seek primary care at the health centers. Relationships were strengthened with the local VA, VSOs, and the veteran community.

Replicating This Innovation: Complete organizational buy-in from the board to the executives and practitioners to make dental health services for veterans a health center priority is required. Cultivate strong community and VA relationships. Dedicate staff and volunteers to make sure that the initiative has the manpower to be successful.

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**CP22**

**Healing Hearts and Paws Program: Helping Veterans Learn to Recognize and Cope With PTS Issues Through Animal-Assisted Therapy**

**Poster Type:** Innovation  
**Category:** Behavioral Health Services; Improving Care for Special Populations; Patient and Community Engagement

**Issue or Challenge:** Veterans sometimes struggle with post-traumatic stress (PTS) issues and can be reluctant to seek help. If PTS is left untreated, it can lead to a litany of mental and physical health problems including severe depression, violent outbursts, and suicide. The Healing Hearts and Paws Program aims to help veterans recognize and cope with PTS issues through Animal-Assisted Therapy activities, counseling for their physical and mental needs, and community outreach and engagement programs.

**Description of Innovation:** Blue Moose Bed & Biscuit (BMBB) is a dog boarding and daycare facility in Soldotna, Alaska that recognized that veterans within their community were suffering from PTS. In the United States: 22 soldiers complete suicide daily due to untreated combat related stress/injuries; up to 68% of returning veterans are diagnosed with PTS within 90 days of returning home; and many veterans have difficulty re-engaging in family and community life when they return home. Alaska has: one of the highest suicide rates in the nation and one of the highest per capita veteran populations (5,500 on Kenai Peninsula).

BMBB decided to pilot a program using therapy dogs to help veterans suffering from PTS. They partnered with a community health center, and the local Veterans Affairs Medical Center to offer immediate help and engagement to veterans with PTS in a non-threatening environment, within their community while encouraging community support and engagement.

**Impact or Result:** Potential pilot outcomes: Increased number of veterans and their families receiving healthcare at local VA and CHC; increased awareness of PTS veteran issue; decrease in suicidal ideation among veterans in the community; and ability to duplicate program in a variety of communities nationwide.

**Replicating This Innovation:** Dog boarding and daycare facilities are found across the country. If a partnership is possible between a health center, the local VA, and the dog boarding/daycare, the program and its curriculum can be adapted to work in most communities.

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**Presenter(s):** Kelly Engstrom, Ellen Adlam, Katie Joselow

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**CP23**

**The Power of the First Phone Call: Factors Influencing Patients’ Likelihood to Return to a Medical Practice**

**Poster Type:** Research  
**Category:** Expanding Access to Care and Other Services; Quality of Care and Quality Improvement

**Research Objectives:** To determine which factors are most important to callers when reaching out to a clinic for information or an appointment.

**Study Design/Methods:** Data was gathered from the Baird Group database of more than 10,000 phone mystery shops. For the purposes of this study, the analytical sample consisted of only complete cases. A case is considered complete if a response is documented for the key empirical and attitudinal variables selected. This resulted in an analytical sample of 1,878 cases representing calls to more than 25 healthcare organizations across the U.S. Research sought to identify empirical and attitudinal elements that influence a caller’s likelihood to return for future care.

**Principal Findings and Quantitative/Qualitative Results:** The findings from this study identify both empirical and attitudinal elements of a call that determine whether or not a first-time caller will ever return. By understanding what is most important, it gives healthcare organizations specific areas of focus for phone training. In addition, it verifies the impact of both service and appointment access on likeliness of returning. The study found that 35% of callers are not likely to call back for future care.

**Conclusions on Impact on Health Centers:** Analysis revealed that specific elements of a call are significantly and independently associated with potential patients’ likelihood to return to a clinic. These include a proper greeting and closing of the call, answering the call within three rings, accessing a live attendant (no voicemail, queue or a transfer), attendant communication (speaking slowly and clearly, not interrupting and asking need-defining questions), and being offered an appointment within two weeks. Patient satisfaction is multidimensional, and findings revealed that satisfaction in a first impression, on the phone, play an important role in forming a potential patient’s likelihood to return.

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**Presenter(s):** Kristin Baird

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**Expanding Access to Care and Other Services**
Developing Common Evaluation Measures to Sustain Community Health Worker Programs

**Poster Type:** Research

**Category:** Expanding Access to Care and Other Services

**Research Objectives:** Develop a common set of evaluation indicators and measures and, possibly, a recommended tool (or tools) to use in pooled analyses by community health worker (CHW) programs nationwide, to better characterize and evaluate the work and impact of CHWs on health outcomes, and to strengthen the economic case for CHWs.

**Study Design/Methods:** The Michigan CHW Alliance conducted a comprehensive literature review of existing CHW evaluation indicators, national key informant interviews, focus groups with CHWs, a CHW program survey, and identified commonalities and gaps for collecting and measuring the roles and impact of CHWs. Next, the Oregon CHW Consortium sponsored an interactive summit where stakeholders from five states created a set of proposed process and outcome indicators for CHW programs. In October 2016, a pre-conference session at the American Public Health Association conference elicited input from a larger group of stakeholders. Efforts to refine common indicators and measures continue during monthly phone meetings.

**Principal Findings and Quantitative/Qualitative Results:** Efforts of CHW experts from across U.S. resulted in proposed CHW common indicators/measures and suggestions for operationalizing them. Proposed outcome indicators include participants': quality of life; food/water/transportation security; access to services; knowledge/attitudes/behaviors; social support; psychological empowerment; civic engagement; CHWs’ job satisfaction; cost of care; and utilization of health services. Proposed process indicators: support organization provides CHWs; organization’s value/acceptance of CHWs; frequency of enactment of 10 core roles; trust/satisfaction with CHW-patient relationship; CHW facilitated referrals; extent to which: CHWs team with others in the system, organizations, and policy-making bodies; CHWs integrated into healthcare teams; and CHWs involved in decision/policy-making process.

**Conclusions on Impact on Health Centers:** The CHW Common Indicators Project’s effort to fill an evaluation knowledge gap by creating a common set of evaluation indicators and measures that capture the unique contributions of CHWs to successful program outcomes, and their added value to healthcare and human services systems, has the potential to advance the integration and sustainability of CHWs in healthcare settings. This work is expected to positively impact health centers since policy makers, health-system leaders and payers are asking for more systematic study to achieve a strong evidence base before making long-term investments in hiring, training, and financing the CHW workforce.

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Presenter(s): Gloria Palmisano

Not Just A Ride: Transportation Matters to Healthcare

**Poster Type:** Research

**Category:** Expanding Access to Care and Other Services

**Research Objectives:** Health Outreach Partners (HOP) conducted the Rides to Wellness Community Scan Project to assess the impact of lack of transportation on healthcare costs by: (1) identifying the percentage of missed appointments due to transportation barriers and (2) quantifying the direct and indirect costs associated with missed appointments.

**Study Design/Methods:** Health Outreach Partners utilized a cross-sectional survey design with a mixed-methods approach. The survey consisted of 25 questions, including short answer, Likert scale, and ranked choice response categories. The survey was sent to over 1,300 health centers using Google mail merge software. The response rate was 15%. Univariate and bivariate analyses were used to analyze survey responses and describe the frequencies and distribution of the collected data. The data was disaggregated by geographic type (rural, suburban, and urban) and analyzed for statistical significance. Qualitative results were coded and analyzed.

**Principal Findings and Quantitative/Qualitative Results:** Ninety-two percent (92%) of survey respondents reported tracking missed medical appointments (n=188). The monthly rate of missed appointments varied, but 66% reported a rate between 11 and 30%. However, only 40% of respondents reported tracking the reasons that patients miss medical appointments. All respondents stated that missed appointments were a problem, and 86% indicated that transportation barriers were a “moderate or serious” problem. Only 23% of respondents reported tracking the cost of missed appointments, with an average cost of $175 per missed medical appointment. No respondents reported consistently tracking the cost of missed appointments that specifically resulted from transportation barriers.

**Conclusions on Impact on Health Centers:** Transportation barriers are a cause of missed appointments. Health centers do not have a uniform system available to consistently track and analyze the cause of missed appointments and associated costs. Providing health centers with a cost analysis tool can help to consistently track missed appointments due to transportation. This data can be leveraged to support investment in patient-centered transportation solutions that can optimize health outcomes, while decreasing costs to the patient and health center. Further research is required to generate a national estimate of missed appointments annually due to transportation and the cost to the health system.
Reducing Emergency Department Visits by Behavioral Health Patients Using an Integrated Health Clinic

Poster Type: Research
Primary Funding Source: ONE Health Ohio
Category: Achieving Savings; Behavioral Health Services; Expanding Access to Care and Other Services
Research Objectives: To determine if there is a reduction in emergency department utilization by behavioral health patients when an integrated health program is offered through a clinical setting.

Study Design/Methods: An interrupted time series study was performed to analyze emergency department (ED) utilization trends for behavioral and mental health (BH) patients in an integrated federally qualified health clinic.

Principal Findings and Quantitative/Qualitative Results: ED visits for medical problems by BH patients declined by 1.108 visits per calendar quarter (p=0.012) after BH counselors were introduced into the clinical program as part of an integrative healthcare delivery service. A control group consisting of non-BH patients revealed negligible decline.

Conclusions on Impact on Health Centers: Integrating on-site BH services as part of a healthcare delivery program results in a decline in ED utilization by BH patients. There are clear economic advantages for this healthcare delivery model.

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Improvements in Community Health Center Accessibility for Low-Income, Non-Elderly Adults in Three Southern States After Health Center Program Funding Increases

Poster Type: Research
Category: Expanding Access to Care and Other Services
Research Objectives: Community health centers (CHCs) provide high-quality care to underserved communities. Limited research has studied policies that expand geographic access to CHCs or CHC accessibility for low-income adults. This study examines changes in CHC accessibility in three southern states after substantial funding increases to the Health Center Program (HCP).

Study Design/Methods: We calculated CHC accessibility for adults in Arkansas, Louisiana, and Mississippi in 2008 and 2016, before and after HCP funding increases. We obtained population estimates of low-income (<200% federal poverty level), non-elderly (18-64) adults at the census tract level from the American Community Survey. Data for CHC locations and year in which CHCs opened were obtained from the Health Resources and Services Administration. We calculated CHC accessibility for each census tract using geographic information systems to create catchment areas around each CHC. We estimated the number of adults in each catchment and accounted for areas served by multiple CHCs.

Principal Findings and Quantitative/Qualitative Results: The number of CHCs across all three states increased by 121%. CHCs grew from 40 to 95 in Arkansas, 40 to 125 in Louisiana, and 70 to 112 in Mississippi. Regarding accessibility, the average number of CHCs per 10,000 low-income, non-elderly adults per census tract increased by 136% (0.67 to 1.58) in Arkansas, 223% (0.43 to 1.39) in Louisiana, and 64% (0.99 to 1.62) in Mississippi from 2008-2016. The number of census tracts with 0 CHCs per 10,000 adults decreased from 276 to 102 in Arkansas, 240 to 55 in Louisiana, and 118 to 34 in Mississippi.

Conclusions on Impact on Health Centers: CHC accessibility for low-income, non-elderly adults increased across all three southern states after increases in HCP funding. Many CHCs opened in rural areas, and many census tracts with no geographic access in 2008 gained access in 2016 thereby decreasing disparities in CHC accessibility for many underserved communities. However, some underserved communities in these states remain without a CHC within a 30-minute driving distance. These results highlight areas that need CHC services and the approach can be extended to identify areas needing specialty services. The information can be used for healthcare policy and planning efforts to target resources to appropriate communities.

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The Impact of Pharmacist-Provided Spirometry Service on Access to Results in Primary Care Settings

Poster Type: Research
Category: Expanding Access to Care and Other Services
Research Objectives: The primary objective is to determine the effect of implementing a pharmacist-provided spirometry service within an FQHC on the percentage of spirometry
referrals completed with results reviewed by the ordering provider.

**Study Design/Methods:** This is an IRB-approved, retrospective chart review comparing data before and after the implementation of the pharmacist-provided spirometry service. Chart reviews were completed to collect patient demographics, type of provider ordering referral, location from where referral was ordered, referral diagnosis, and status of referral. For those who received spirometry screening from a pharmacist at PrimaryOne Health, chart reviews also included any medication recommendations made based on spirometry results and provider acceptance/denial of recommendation. Revenue was evaluated through a Revenue Detail Report provided by the billing department at PrimaryOne Health.

**Principal Findings and Quantitative/Qualitative Results:** Preliminary results show an increase in the percentage of spirometry referrals completed and reviewed by the ordering provider from 38.1% to 50.9% after initiation of the pharmacist spirometry screening. Preliminary results also show that pharmacists were able to provide 19 accepted medication recommendations.

**Conclusions on Impact on Health Centers:** The spirometry service at PrimaryOne improves patient convenience by allowing them to schedule and complete the test at their usual doctor’s office. Preliminary results of this study suggest that providing an in-house spirometry service within a FQHC increases access to results for the ordering provider. With results, the provider is able to prescribe evidence-based treatment off the appropriate diagnosis to enhance patient outcomes. Spirometry screening represents an emerging role for pharmacists in primary care and could be adopted in other primary care settings.

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**Presenter(s):** Buhari Mohammed

**CP29**

The Emergency Department Diversion Liaisons Center Model Hub: Success and Lessons Learned

**Poster Type:** Innovation

**Category:** Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Social Determinants of Health

**Issue or Challenge:** The Bronx Community Health Network (BCHN) was established in 1996 as a not-for-profit community-based organization and FQHC. BCHN’s mission is to improve the health of the people in the Bronx by providing access to quality and affordable healthcare and health education for wellness and disease prevention. BCHN established the Emergency Department Diversion (EDD) program in 2007. The EDD liaisons help to decrease the over-utilization of the ED for non-urgent cases, which reduces costs to the overall health system and frees up the emergency department for truly urgent cases.

**Description of Innovation:** BCHN established the Emergency Department Diversion (EDD) program in 2007 to decrease ED utilization for non-urgent cases. To divert patients away from the EDs to health centers for primary care. The EDD program utilizes an EDD liaison in the Weller Emergency Department of Montefiore Medical Center (MMC). The EDD liaison program goals are to: (1) identify patients with non-urgent matters; (2) determine these patients’ need for a primary care physician (PCP); and (3) provide patients without a PCP access to BCHN health centers. To accomplish this goal, BCHN employs an EDD liaison that facilitates outpatient care at BCHN health centers. By linking patients to the BCHN community health centers, the EDD liaisons help to decrease the over-utilization of the ED for non-urgent cases, which reduces costs to the overall health system and frees up the ED truly urgent cases.

**Impact or Result:** Through the implementation of the EDD program, lessons learned were demonstrated by patients being re-directed from inappropriate ER use. EDD Liaison Model of Care Coordination can be a key factor in the success of new care models: Patient-Centered Medical Home, Health Homes, and Accountable Care Organizations. Coordination and follow-up at all levels is key to successful referrals. EDD liaison familiarity with both ED and health center processes is essential; utilizing the EDD liaisons’ community knowledge to conduct grassroots outreach is essential; and recruitment of the right people and team work are crucial.

**Replicating This Innovation:** To develop this program at other organizations, you will need to get buy-in from the ED and health center leadership; establish roles, responsibilities, and reporting process; finalize logistics: orientation, space, access to information systems, training, feedback, establish referral process, review ED utilization data, and recruit the ED liaison. Through establishing a referral process, you must review previous and/or current referral efforts, identify ED and health center referral processes, document revised processes and get agreement, discuss “what ifs?” and establish contacts at the health centers to facilitate appointments and resolve issues.

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CP30
Closing Gaps in Care: Emergency Department Follow-Up in the Outpatient Community Health Center Setting

Poster Type: Innovation
Category: Expanding Access to Care and Other Services

Issue or Challenge: For this project, we target patients seen in a local emergency department (ED) and lack a place to seek follow-up care. Often these patients are uninsured or underinsured, do not have access to a primary care provider, or cannot access their primary care provider within a timeframe that meets good standard of care guidelines, resulting in return trips to the ED. These inappropriate utilizations cost the patients a tremendous amount of money, divert critical healthcare resources, and do not improve the overall health indicators of chronic conditions. Our follow-up clinic addresses all of these issues.

Description of Innovation: In addition to serving as our CMO, our medical director is also board certified in emergency medicine and practices emergency medicine in local EDs, so he and his partners first identified the significant gap in care. In planning the follow-up clinics, we spoke with hospital care managers and discharge planners, emergency department staff, and patients. We discussed marketing, billing, and access and developed systems which would allow a patient to be seen either during the weekly clinic, or at the time frame specified by the treatment provider from the ED.

When a patient is seen in the ED, and either the physician or patient identifies they have no plan for adequate follow-up care, the patient is referred to our practice. The patient is given a window of time they can simply walk in or they can call and make an appointment. The Open Access scheduling operates a minimum of 4 hours per week, for a total of 24 hours per month. If the patient is already connected to a primary care provider, we take care to return the patient to their regular provider. If the patient does not have a regular provider, we work to engage the patient in ongoing preventative health and primary care services. If the patient has insurance or benefits issues, our enrollment specialist will assist the patient. Case managers are also available to assist the patient with eliminating other barriers to care.

Impact or Result: One result of the innovation has been an increase in the number of primary care patients to the practice. Additionally, the ED now has a place to refer patients to for follow-up if they have no resources or do not have an adequate plan for follow-up. Anecdotally, the ED physicians report a reduction in the number of inappropriate utilizations, and that they refer at least 30% of all non-admissions to our practice. The first patient we saw for ED follow-up was an underinsured, newly diagnosed diabetic. The patient had run out of samples provided at the ED and could not afford refills. The patient was terrified of quickly becoming ill. Our physician spent more than 45 minutes explaining his diagnosis, provided an affordable prescription, and scheduled appointment for later the same day with the nutritionist. This cost the patient $15.

Replicating This Innovation: This project can be replicated by first identifying whether this gap in care exists in your community. If so, it is critical to have the buy-in from emergency department physicians who believe this is an important and worthwhile endeavor. To this end, it is important to find an emergency department physician or physician group who believes this is a need and program worth replicating. Have them champion the effort and spread the word with their colleagues. Next, identify additional barriers to care for patients such as scheduling or managed care problems and then work with managed care entities to eliminate the barriers to care. Finally, roll the program out slowly to allow for a PDSA cycle so you can adjust to any changes which many need to be made.

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Presenter(s): Eric Yazel, Beth Keeney, Greg Duncan

CP31
nccPA Health Foundation: Promoting Physician Assistants as Oral Healthcare Team Members

Poster Type: Innovation

Primary Funding Source: Funding for the PA Leadership Initiative in Oral Health is provided by the National Interprofessional Initiative in Oral Health (NIIOH) and their funders, the Dentaquest Foundation and Washington Dental Service Foundation.

Category: Expanding Access to Care and Other Services; Workforce

Issue or Challenge: The Surgeon General identified oral disease as the “silent epidemic,” noting its disproportionate impact on vulnerable and underserved populations. More than 51 million school hours and 164 million work hours are lost annually due to dental disease, contributing to educational disparities and decreased productivity. The oral-systemic connection suggests that findings in the mouth may provide indications about overall health. Finally, the Health Resources and Services Administration has reported that more than 51 million people live in dental health profession shortage areas and identified physician assistants (PAs) as providers who could be equipped with oral health competencies to bridge this gap.

Description of Innovation: The Surgeon General, the Institute of Medicine, and others have called for equipping providers with oral health competencies to increase access to care. Certified PAs are uniquely qualified to embrace oral health because screening, risk assessment, and behavior change counseling are fundamental to the profession. Over 115,000 certified PAs practice in all settings and specialties, and 8,000 PAs join the workforce annually allowing the profession to add...
quickly providers equipped to expand access in the profession’s more than 400 million patient visits each year. In 2010, the PA Leadership Initiative in Oral Health deployed a collective impact strategy that leverages the influence of the national PA organizations to push levers for change toward shared goals of reducing health disparities and eradicating dental disease. Annually, PAs and interprofessional partners identify strategies that integrate oral health into education and practice. This session’s purpose is to describe the PA profession’s progress to add PAs as members of the oral health team as a model for the future, including efforts by standard-setters (accreditation standards review and examination content design), educators (faculty and interprofessional workshops, CME, curriculum design), and students and clinicians (interest and leadership groups, community outreach for service learning and clinical training, educational videos and tools). Evaluative studies and metrics demonstrate that the collective impact model is equipping PAs to expand workforce capacity as partners for addressing this preventable public health crisis.

**Impact or Result:**
Over the last seven years, the PA profession has sustained its commitment to oral health and collected data, including numbers of PAs participating in CME activities and grants, as well as evaluative studies and metrics. A 2014 evaluative study found 78% of responding PA programs (n=125) provided oral health instruction, an uptick from a 2008 study that found only 33% of responding programs (n=83) provided instruction. In addition, a 2015 study found that 32% of PAs responding to a national practice survey encounter oral disorders at least weekly, establishing a new benchmark and underscoring the need for sustained commitment and the sharing of innovative models and strategies across institutions and the health professions.

**Replicating This Innovation:** The PA profession is growing rapidly; and the Bureau of Labor Statistics projected the profession to grow 30% from 2014-2024, which is much faster than the average for all occupations. Similarly, there continues to be significant growth in PA education with 218 accredited programs and more in the pipeline. Moreover, the rapid educational preparation of PAs fosters the profession’s ability to serve as a champion for the integration of oral health in practice. The development of tools and resources, as well as the continued application of funding and practice innovation strategies positions PAs to sustain and share their participation on the oral healthcare team with other health professions.

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¹nccPA Health Foundation

**Presenter(s):** Ted Wendel

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**CP32**

**HBV ECHO: Reducing Perinatal Transmission**

**Poster Type:** Innovation

**Primary Funding Source:** This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under contract number HHSH250201600015C.

**Category:** Expanding Access to Care and Other Services

**Issue or Challenge:** Approximately 25,000 infants are born to hepatitis B virus (HBV)-infected mothers in the U.S., with an estimated 1,000 new infections each year. Chronic HBV is preventable in up to 90-99% of babies born to HBV-infected mothers if immune globulin and vaccines and nucleotide analogues are administered. The project’s goal is to increase primary care clinician knowledge at HRSA-funded health centers to maximize services aimed at preventing perinatal transmission of HBV. This project addresses Recommendation 4-2 of the recently released “A National Strategy for the Elimination of Hepatitis B and C: Phase 2 Report” from the National Academies of Science, Engineering, and Medicine.

**Description of Innovation:** The ECHO model was developed to increase access to specialty care for underserved patients. Utilizing videoconferencing technology, a team of experts connect with clinicians and their medical teams from around the country. These experts provide multidisciplinary teaching to clinicians serving underserved communities using a case-based approach. These virtual sessions are called teleECHO clinics. HBV is a chronic infectious disease that can be managed and treated in the primary care setting utilizing the ECHO model. This project is the first teleECHO focused on perinatal HBV prevention and was developed solely for HRSA-funded health center clinicians and their medical teams. Participants receive formal mentorship and training, and the opportunity to discuss patient cases and health center challenges related to vaccination and other HBV prevention and treatment issues. This allows participants the ability to provide specialized services to their community and enhance their clinical skills and practices. Additionally, this project is unique in that it offers a virtual learning community to allow participants to access and share resources and materials and engage in offline discussion.

**Impact or Result:** Increased self-reported knowledge and competence of medical care teams in the treatment and care of HBV patients; increased medical teams’ ability to improve clinical processes to better support the needs of HBV patients; multidisciplinary network established to improve care for HBV patients in the United States; and developed and fostered a community of practice to guide best practices of HBV care in the primary care setting.

**Replicating This Innovation:** Project ECHO provides ample opportunity to replicate all of its innovative projects and freely shares all materials. Organizations interested in replicating this project, or other Project ECHO initiatives, can sign up for the monthly orientation and immersion training on their website.
The ECHO model was successfully replicated by many partners globally and new ECHO initiatives continue to launch.

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**Presenter(s):** Karla Thornton

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**CP33**

**Engaging Community Health Center Stakeholders to Reduce Health Disparities: An Increase in Knowledge and Health Literacy for Preterm Birth**

**Poster Type:** Research

**Primary Funding Source:** National Institute on Minority Health and Health Disparities (P60MD002256)

**Category:** Patient and Community Engagement

**Research Objectives:** Health disparities negatively impact subsets of the population to systematically experience socioeconomic obstacles to health, such as those observed in fetal and infant mortality among African Americans compared to Caucasians.

**Study Design/Methods:** The Preterm Birth Prevention Project (PBPP) is a five-year, federally funded effort to determine if computer-based education can increase health literacy knowledge and behavior of participants in underserved communities in Richmond, Virginia where preterm birth, a leading cause of infant morbidity/mortality, has been found to occur at twice the national average. In a community-based participatory research approach, modules were developed under the guidance of an advisory board of community health center nurses and outreach workers, service agencies, community residents/patients, and university researchers. The intervention included knowledge tests, continuing education links, and skill-building workshops featuring content, facilitators, and logistics by community-design.

**Principal Findings and Quantitative/Qualitative Results:** Descriptive statistics, means, standard deviations, and paired t-tests were conducted in SPSS 22.0 on data from n=250 public housing residents, ages 18 years or older. Findings were significant, P<.0001, for each module regardless of gender or prior preterm birth experience. Over the course of intervention, 45 stakeholders contributed to project design representing 15 community organizations. Eight workshops yielded an average community attendance of 65 participants.

**Conclusions on Impact on Health Centers:** Researchers found content tailored and promoted by community stakeholders demonstrated an increase in knowledge as well as participation in collaborating initiatives (e.g., workshops, resource/project development, health center patronage). Community health centers can consider this approach to increase patient-community engagement for service results, e.g., computers can enhance access to services without increase in care or personnel costs and electronic links may support patients with immediate referrals. Future applications can also reflect on this project’s engagement challenges as well as outreach activities which worked well. This research receives support from the National Institute on Minority Health and Health Disparities (P60MD002256).

**Author(s):**

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**Presenter(s):** Marcie Wright

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**CP34**

**Elevating Patient Voices: Conducting and Disseminating Health Experiences Research in a Community Health Center Research Network**

**Poster Type:** Research

**Primary Funding Source:** Agency for Healthcare Research and Quality

**Category:** Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Social Determinants of Health

**Research Objectives:** Evaluate the feasibility of implementing the DIPEx (Database of Individual Patient Health Experiences) methodology within the Community Health Applied Research Network (CHARN), a network of federally supported community health centers created to build capacity for conducting PCOR (Patient Centered Outcomes Research) in safety-net populations.

**Study Design/Methods:** Engaging and understanding the perspectives of patients and their caregivers is a critical component of PCOR. But there is limited evidence of how to
do this effectively with a broad range of patients, including the safety-net population. DIPEX, an innovative evidence-based methodology for eliciting rich information on patient health experiences, was developed at Oxford in 2001 and can be leveraged to enhance patient engagement and integrate patient experiences into the design and conduct of PCOR. A participatory and iterative formative evaluation was conducted to discover if the DIPEX methodology would be relevant and beneficial to safety-net stakeholders.

**Principal Findings and Quantitative/Qualitative Results:** Findings suggest the DIPEX methodology is relevant and would be beneficial within the safety-net population. Safety-net stakeholders wanted to know more about patient experiences related to social determinants of health, chronic disease, and the role of caregivers. Barriers highlighted include: (1) digital footprint of publicly sharing one’s health experience; (2) tension between trained interviewers who aren’t from the community versus local interviewers who may have more rapport with community members; (3) concerns about sustainability given the resources needed to conduct a single module; and (4) difficulty of capturing the full range of experiences in the U.S. context.

**Conclusions on Impact on Health Centers:** If implemented successfully, the DIPEX methodology could: (1) enhance engagement and improve understanding of the health experiences of safety-net patients; (2) enable the development of a qualitative data repository; and (3) improve dissemination by making findings publicly available in a format that is accessible and useful to patients, caregivers, clinicians, researchers, and other stakeholders. However, adaptations may be needed to increase the efficiency and appropriateness of this approach, including leveraging technology to facilitate recruitment and dissemination, and experimenting with alternative methods of data collection (e.g., providing patients with equipment to record their own stories and/or conducting interviews virtually).

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**Presenter(s):** Erika Cottrell; Molly Krancari

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**CP35**

**Sharing Notes - An Avenue to Greater Patient Engagement: The OpenNotes Story**

**Poster Type:** Research

**Primary Funding Source:** Robert Wood Johnson Foundation, Moore Family Foundation, Peterson Foundation, Cambia Health Foundation

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**CP36**

**Engaging Patients as Partners in Managing Hypertension Through Home Blood Pressure Monitoring**

**Poster Type:** Innovation

**Primary Funding Source:** Center for Care Innovation

**Category:** Patient and Community Engagement

**Issue or Challenge:** A large proportion of patients in community health centers (CHCs) have hypertension. Many CHCs are interested in engaging patients in their care by starting a home blood pressure monitoring (HBPM) program. HBPM was recommended by the U.S. Preventive Task Force in October of 2015. While many education tools are available,
there is a lack of information from CHC patients on their needs and a comprehensive set of evidence-based materials that are easy to understand. A human-centered approach was used to partner with patients and care teams using the tool of co-design to develop materials for a HBPM pilot.

**Description of Innovation:** The innovation was an active partnership with CHC patients diagnosed with hypertension and care teams within CHCs to develop a human-centered designed program aimed at engaging patients in their healthcare through home blood pressure monitoring. Patient engagement was manifested through patient participation in multiple co-design sessions to: (1) understand CHC patients as people, their needs, and challenges; (2) determine interest among patients in a HBPM program to engage them in the management of their hypertension; (3) assist with developing patient education materials and procedures for a standardized program; (4) evaluate participation in a pilot program; and (4) post pilot feedback through another co-design session and written survey.

Co-design sessions are a tool used in human-centered design. In this innovation, focusing on blood pressure monitoring, co-design sessions were conducted to understand the perspective of patients with hypertension and include their feedback in the design of program materials and procedures needed to learn how to take their blood pressure, understand their readings, and document and act on their results. These sessions incorporated the input of patients in the design of a program prior to implementation. In our innovation, the co-design sessions also extended to the care teams within CHCs to determine clinical needs and limitations of the current infrastructure in the delivery of healthcare to hypertensive patients. This innovation included partnership between a consortium (Health Quality Partners of Southern California), a funder (Center for Care Innovations), and two California CHCs.

**Impact or Result:** Thirty-nine patients and 15 health center staff participated in the pilot. The pilot was 17 days in duration and included: a face-to-face orientation session between a care team member and the patient; distribution of a blood pressure monitor and patient materials and resources on blood pressure monitoring; documentation of blood pressure readings for 14 days; and a 7-day follow-up phone call and visit. Compliance and blood pressure data was collected from all pilot participants as well as qualitative data from the follow-up calls/visits. Upon completion of the pilots at both sites, co-design sessions were held with a sub-sample of pilot participants to gather qualitative feedback on their experience and the materials. A confidential written survey was also conducted.

A total of 39 patients agreed to participate in the pilot. Of these, 39 (100%) completed an orientation session, 36 (92.3%) completed the initial follow-up call, and 35 (89.7%) completed the final visit/call.

**Replicating This Innovation:** We aimed to establish standardized education materials to assist patients with taking their blood pressure at home correctly, understanding their readings, and provide recommended action to take if they have a reading outside their recommended range. Based on our pilot, replication of this innovation would be beneficial. Feedback from patients confirmed that the tools were helpful and they learned what behaviors raised or lowered their blood pressure. Care teams also thought this would be a benefit to offer in their health centers.

The materials, developed through partnering with patients and care teams, lend themselves well to replication in other health centers. Further investigation on the demonstration of blood pressure control through at home blood pressure monitoring would be beneficial. This could include a focus on specific patients such as newly diagnosed, hiding in plain site, and those with a long-term diagnosis but do not have their hypertension under control.

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**CP37**

**Recruitment Strategies Among Diverse, Low-Income Patients With Chronic Disease at a Community Health Center**

**Poster Type:** Research

**Primary Funding Source:** NIH Grant #5R01HL120907-03

**Category:** Patient and Community Engagement

**Research Objectives:** Research aimed at including low-income diverse patient populations should consider possible challenges or barriers to recruitment. This poster presents effective participant recruitment strategies used among linguistically, culturally, and socioeconomically diverse patient populations in the Medication Adherence, Health Literacy and Cultural Health beliefs study (RxHL).

**Study Design/Methods:** The RxHL study examines medication adherence, health beliefs, and health literacy among five racial/ethnic groups with chronic disease(s) at a federally qualified community health center. Eligibility criteria includes: (1) self-reported race/ethnic identity as African-American, Hispanic, Russian-speaking immigrant, Vietnamese immigrant, or white; (2) diagnosis and use of daily oral prescription medication for at least one of the following conditions: hypertension, diabetes, dyslipidemia, and/or depression; and (3) 18+ years of age. Five hundred patients will complete self-report surveys and manual pill-counts. A subsample of participants completes qualitative data collection activities including in-depth interviews, home observations, and chronic disease diaries.

**Principal Findings and Quantitative/Qualitative Results:** General recruitment methods (N=444) included: (1) provider care team referral based on use of disease-specific registries and daily clinical schedule; and (2) self-referral. Additional strategies included incorporating bilingual interviewers into the clinical setting, in-person screening with potential
participants, providing all materials in the patients' language of choice, offering in-home interviews, and bi-weekly team meetings to brainstorm enrollment and attrition challenges. In addition, some methods varied depending on the patient group. For example, many Vietnamese participants were recruited through key community members and networks, whereas Russian-speakere were more likely to participate if the health center's Russian-speaking primary care provider referred them.

**Conclusions on Impact on Health Centers:** Recruitment of diverse patient populations into research studies can often be challenging and requires additional consideration. The RxHL study uses a mixed methods approach to understand barriers to managing chronic disease across five racial/ethnic groups in a CHC setting. RxHL has effectively recruited a diverse sample by implementing culturally tailored recruitment methods that reduce barriers to participation. Strategies for increased enrollment and retention of diverse patient populations in research is needed to effectively understand and address racial/ethnic disparities in health.

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**Public Health Crises**

**CP38**

**Opioid Review Committee: Implementing a Controlled Substance Policy and Clinic-Based Monitoring Program to Ensure Patient Safety and Provider Support**

**Poster Type:** Innovation  
**Category:** Public Health Crises; Quality of Care and Quality Improvement; Technological Solutions and Tools to Improve Care and Population Health Management

**Issue or Challenge:** The Centers for Disease Control and Prevention (CDC) report that prescription opioids now account for more overdose deaths than heroin and cocaine combined. They recommend that when non-opioid treatments are insufficient to manage pain, healthcare providers carefully screen and monitor patients using opioids. To assist Community Health Center, Inc. (CHCI) providers in achieving this goal, an Opioid Review Committee (ORC) was formed to provide quarterly reviews of controlled substances prescriptions to assure quality, patient safety, and to provide feedback and support to prescribers.

**Description of Innovation:** A standing ORC is maintained as part of the CHCI Pharmacy and Therapeutics (P&T) Committee. The ORC uses data from the agency’s clinical dashboards with periodic-focused chart reviews and provider-specific scorecards to monitor opioid prescribing at CHCI. The ORC makes recommendations to the P&T Committee regarding changes to the Prohibited Medication and Medications Requiring Second Tier Review lists, and provides focused support for providers practicing outside CHCI’s policies and/or the established standard of care for pain and opioid management.

**Innovation: Impact or Result:** CHCI and the ORC created a Controlled Substance Policy that is based on current practice guidelines and requires that all patients receiving 90+ days of opioid prescriptions have: (1) a treatment agreement; (2) urine toxicology screens at least once every six months; (3) pain and functional status reassessed at least every three months; and (4) routine checking of the Connecticut Prescription Monitoring Program. In addition, the policy recommends interdisciplinary co-management between primary care and behavioral health providers. An ORC allows for an agency to take a supportive role in aiding primary care providers in managing chronic opioid prescriptions within defined standards. Furthermore, as standards change, it ensures continuous monitoring and evaluation of overall opioid prescribing across a large system, thereby identifying providers requiring additional supports to better facilitate practice-change.

**Replicating This Innovation:** As standards change, creating an ORC ensures continuous monitoring and evaluation of overall opioid prescribing across a large system, thereby identifying providers requiring additional supports to better facilitate practice-change. Most health centers have access to prescribing data, a Chief Medical Officer and Pharmacy & Therapeutics Committee to assist leading this type of change across an organization.

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**CP39**

**Innovation Across Sectors to Prevent Childhood Lead Poisoning**

**Poster Type:** Innovation  
**Category:** Public Health Crises

**Issue or Challenge:** Lead poisoning in children imposes lifelong health consequences. Lead exposure in childhood has gained national attention due to public health crises of toxic lead exposure in sources such as water and paint. In Chicago, where almost 90% of available housing stock was constructed prior to lead paint bans, nearly 2,000 children
are lead poisoned every year. Elevated blood lead levels (BLL) in children are associated with adverse cognitive outcomes, lower IQ, and poorer education achievement. Collaborations engaging data science, public health, education, and healthcare can be leveraged to address this issue at the individual patient level.

**Description of Innovation:** This Quality Improvement project is a collaborative effort among the Chicago Department of Public Health (CDPH), Chicago Public Schools (CPS), Chicago Department of Innovation and Technology (DoIT), the University of Chicago’s Center for Data Science and Public Policy (DSaPP), the Public Health Institute of Metropolitan Chicago (PHIMC), and AllianceChicago to deploy technologies that can empower pediatricians and obstetric providers in proactively identifying lead risk and mitigating adverse outcomes.

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.

The aims of the project are to: (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; and (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.

**Impact or Result:** As a result of this innovation and the collaborations enabled by this project, a sophisticated predictive model has been developed to predict the risk of a child being lead exposed by their geography. Additionally, custom clinical content has been developed in the EHRS to support providers in identifying risk among unborn infants by identifying risk in the homes of pregnant women and by identifying children who are living in homes with lead previously detected. In a population that may be transient, this allows providers to understand their risk based on their environmental exposures. In addition, this provides clinical decision support for providers and additional resources for patient education on lead abatement strategies and identifies thresholds of risk for pursuing Visual Lead inspections.

**Replicating This Innovation:** The first step is developing a collaborative relationship with multiple sectors. By harnessing the ability to share data with health departments, the principles of this project can be applied to numerous other areas where public health surveillance is important for CHCs. This includes surveillance for cardiovascular risk or sexually transmitted infections. The strength of this project was the expertise of each participating organization (public health, education, data science, and healthcare in CHCs) that was leveraged to take a proactive, rather than reactive, approach to lead risk among children.

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**CP40**

**Austin Medical Center: A Public Health Collaborative in the Midst of an Unprecedented HIV Outbreak Due to Intravenous Substance Abuse**

**Poster Type:** Innovation

**Category:** Public Health Crises

**Issue or Challenge:** This program targets an ongoing outbreak of human immunodeficiency virus (HIV) and viral hepatitis related to syringe-sharing partners in a rural county in southeastern Indiana. Identified by the Centers for Disease Control as one of the worst HIV outbreaks due to intravenous drug use in American history, those impacted by the outbreak have multigenerational substance abuse issues and mental health disorders, as well as significant comorbid physical health conditions. Unemployment and poverty rates exceed the regional, state, and national averages. Access to quality affordable healthcare is virtually nonexistent.

**Description of Innovation:** During innovation, we worked with local health officials including the county health department and county hospital leadership. We also worked extensively with public health nurses who were implementing the state’s first syringe exchange program and the county health officer who was overseeing the local response to the declared state of emergency. We worked with disease investigation specialists, substance abuse therapists, case managers, and many other professionals. We also met with CDC and HRSA officials who were part of the response. We regularly sought the advice and counsel of our HRSA Project Officer.

Our innovation is a collocation of an FQHC access point and a county health department in a rural community with a high rate of IVDU and comorbid HIV and hepatitis C. Through a clearly defined collaboration with the county health department, we were able to create a medical center in the geographic center of a population that had little to no transportation. At the medical center, patients can access the following services without regard to their ability to pay: comprehensive primary care; infectious disease testing; care and coordination, and treatment; immunizations; PrEP/PEP services; medication-assisted substance abuse...
treatment; syringe exchange services; outpatient substance abuse services; outpatient behavioral health services; vital records; benefits acquisition; marketplace enrollment and maintenance; case management services; transportation assistance; referrals to other local and state agencies; and other services. No patient is turned away due to inability to pay by either provider.

**Impact or Result:** Prior to the collocation with the health department, there was only one healthcare provider in the target area. We were able to open Austin Medical Center, which has separate and distinct providers who share the common goals of reducing HIV and viral hepatitis transmission, reducing mother-to-baby transmission of infectious diseases, improving the health of those experiencing chronic conditions, assisting families with accessing safety-net services, reducing inappropriate emergency department utilizations, and increasing access to healthcare. Between the health center and the health department, patients in a rural community, are able to walk to our facility, access syringe exchange services, infectious disease care, primary care, benefits assistance, behavioral health and substance abuse treatment services, as well as many other services in one location. This model is essentially a medical mall for our target population and we have provided care to more than 500 patients, or 12% of the town.

**Replicating This Innovation:** The first step to replicating this innovation is to identify a public health partner to collaborate with. We have found our local health department to be our ideal partner. Many times, community health centers can get into tricky waters with syringe exchange programs due to federal funding restrictions, so partnering with an entity who isn’t bound by the same regulations is ideal. Having a clearly written memorandum of agreement is essential so that each partner knows what is expected is critical. This eliminates confusion for staff, and more importantly, patients about who will be doing what. Whenever possible, collocate services to reduce barriers to care. When serving populations who inject intravenous drugs, closely integrate behavioral health and substance abuse treatment.

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**CP41**

*Improving Access to Naloxone – Community Health Worker-Led Opioid Overdose Prevention Program in Bronx, New York*

**Poster Type:** Innovation

**Category:** Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Social Determinants of Health

**Issue or Challenge:** The Bronx has the highest rate of heroin-involved overdose deaths in New York City, increasing by 158% between 2010 to 2015 to 13 per 100,000 residents. Naloxone is a safe medication that reverses opioid intoxication and can be administered by trained laypersons to prevent overdose deaths. Medication availability and costs, lack of awareness among patients and medical providers and stigma around substance use can limit access to naloxone for persons at risk of experiencing or witnessing opioid overdose. Our aim was to improve access to naloxone by providing free trainings and kits in a network of community health centers in Bronx, NY.

**Description of Innovation:** Naloxone distribution events are held bimonthly in community health center waiting rooms. Patients, families, friends, and caregivers can voluntarily approach the table to receive naloxone training while waiting to be seen by their clinical providers. The training is conducted by a community health worker (CHW) and does not require a medical referral or prescription. The CHW educates individuals on how to recognize opioid overdose and respond with intranasal naloxone. Individuals then demonstrate back trained steps, including the assembly and administration of intranasal naloxone. At the end of the brief training, individuals receive certificates as trained overdose responders and naloxone kits that contain information on opioid overdose prevention.

By offering naloxone training in health center waiting rooms, we integrate opioid overdose prevention into routine primary care and expose patients and their support network to a life-saving medication that they may not have been aware of. We provide an important service for medical providers who lack dedicated time during visits to educate patients on opioid overdose prevention. We also make naloxone training available to anyone interested in being an opioid overdose responder, including individuals who do not use opioids but know someone who does. We reach a broad population of patients who may not be screened for naloxone eligibility by their medical providers. In addition, by training family members, friends, and caregivers who accompany patients but do not receive care at the health center, we provide naloxone to community members who may not have access to opioid overdose prevention education elsewhere.

**Impact or Result:** Between October 1, 2016 to March 31, 2017, the CHW conducted 26 waiting room naloxone trainings at five participating Montefiore community health centers. As a result, 137 community members were trained in opioid overdose prevention and 130 of them received intranasal naloxone.
kits. The few individuals who completed naloxone training, but declined kits cited having access to naloxone already in possession by family or friends. In tandem with waiting room trainings, the CHW also trained over 100 health center medical providers and staff members on how to educate patients in naloxone use for opioid overdoses. An important observation from the first six months of this initiative is that waiting room tabling is an acceptable and effective way for community members to access naloxone at four of the five participating health centers. The CHW distributed more naloxone kits per month through waiting room trainings compared to those distributed by medical providers.

**Replicating This Innovation:** Other health centers can replicate naloxone trainings in their waiting rooms if similar legislations exist in their states or cities to allow non-patient specific naloxone prescriptions for trained laypersons. Fostering community health worker leadership in naloxone training facilitates dissemination across a network of health centers, and integrates opioid overdose prevention education with linkage to primary care, social services, and community resources.

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**CP42**

**Using Project ECHO to Combat the Opioid Epidemic With an Integrated Approach to Patient Care**

**Poster Type:** Innovation

**Category:** Technological Solutions and Tools to Improve Care and Population Health Management

**Issue or Challenge:** While treating patients for chronic pain or addiction, providers in community healthcare settings are frequently presented with both medical and behavioral comorbidities that affect their patient’s ability to adhere to care plans. A holistic, multi-disciplinary approach is vital in order to provide high-quality care to this complex patient population. However, primary care medical and behavioral health providers are often unfamiliar with how the complexities of the opposite discipline may be impacting the patient’s overall health. In order to combat the current opioid epidemic, it’s vital that both disciplines learn how to communicate to move patients’ care forward.

**Description of Innovation:** The Weitzman Institute (WI) was an early adopter of the Project ECHO model developed by the University of New Mexico. Weitzman ECHO is unique in its use of practicing primary care-based faculty combined with specialists who understand the challenges faced by front line primary care and behavioral health providers. Weitzman ECHO Pain and Buprenorphine participants join regularly scheduled videoconferencing sessions in which an expert, multidisciplinary faculty presents a didactic topic from a curriculum teaching the best practices of care in the in chronic pain treatment and medication-assisted treatment for substance use disorder, provides specific recommendations on cases presented by participants, and answers both clinical and programmatic questions.

In each clinic, the faculty team addresses topics from both a medical and behavioral health perspective. Weitzman ECHO Buprenorphine didactic topics have included the following: Psychosocial Treatment of Substance Use Disorders, Motivational Interviewing, Co-Occurring Substance Abuse, and Treating Co-Occurring Mental Health Disparities in the Context of Substance Abuse. Weitzman ECHO Pain didactic topics have included: Best Practices in Pain Management, Psychological Factors Affecting Pain, Psychological Nervous System Trauma and Pain, and a series of six didactics regarding Opioid Prescribing. In addition, due to the multidisciplinary nature of each faculty team, every patient case is addressed from both a medical and behavioral health perspective.

**Impact or Result:** Since 2013, 89 behavioral health and 134 medical providers have participated in Weitzman ECHO Buprenorphine. Since 2012, 89 behavioral health and 351 medical providers have participated in Weitzman ECHO Pain. Quantitative data from satisfaction and self-efficacy surveys administered to participants of both ECHO clinics suggest that, following participation, providers are more likely to refer patients to the opposite discipline and that medical providers are more likely to recognize patients’ need for behavioral health interventions. Qualitative data further supports this; providers have reported how learning about the opposite discipline has been beneficial. This poster will address three elements of ECHO participation that lead to integrated care: if providers are more likely to refer to the opposite discipline, if providers are more confident in recognizing the impact of medical/behavioral health conditions on their patients; and if providers are more likely to communicate with the opposite discipline in treating a shared patient.

**Replicating This Innovation:** Organizations have the option to join a pre-existing Project ECHO program, ensuring they select one that has a strong focus on integration, or to begin their own. Weitzman ECHO is a national program, with participants from 25 states and new participants are always welcome. If an organization is looking to fully replicate the intervention including holding its own Project ECHO sessions, ECHO is a replicable model and training is provided regularly by the University of New Mexico in becoming an ECHO hub.

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**CP44**

**Effect of Mailing FIT Tests Directly to Patients on Provider Colorectal Cancer Screening Rates**

*Poster Type:* Research  

*Category:* Quality of Care and Quality Improvement  

*Research Objectives:* To determine if fecal immunochemical tests (FIT) mailed directly to patients' homes results in more patients completing colorectal cancer screening compared to those given out in person at clinic appointments.

*Study Design/Methods:* FIT tests were mailed directly to all patients who were due for colorectal cancer screening from the panels of two clinic providers in April 2016. The total number and the percent of mailed FIT tests returned were compared to the total number and percent returned of tests given out at clinic appointments for all clinic providers, as well as for the two selected pilot study providers, over the previous three months.

*Principal Findings and Quantitative/Qualitative Results:* Patients from the cancer screening panels of the two study providers returned 20 of 120 FIT tests mailed in April 2016 for a return rate of 16.7%. From January through March 2016, patients returned 15 of 27 FIT tests given out in clinic by these two providers, a 56% return rate. Patients returned 63% of 436 tests given out by all clinic providers over a similar time frame. Revenue from billing for returned tests exceeded mailing costs for the pilot study. Mailing yielded four positive test results that may not otherwise have been identified.

*Conclusions on Impact on Health Centers:* Despite patients returning a low percentage of mailed FIT tests, the total number of mailed tests returned exceeded the total number of tests returned by patients given tests in clinic, by the two selected providers, over the previous three months, leading to an increased colorectal screening enpanelment rate for the two providers. Mailing FIT tests has the potential to identify empanelment patients at risk for colorectal cancer who may not get screened otherwise, without negative financial implications to the clinic.

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*Presenter(s):* Tiffany Mitchell

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**CP43**

**Improving Access to Care for Patients With Hepatitis C in Primary Care**

*Poster Type:* Research  

*Category:* Expanding Access to Care and Other Services; Quality of Care and Quality Improvement  

*Research Objectives:* The objective of this project was to improve access to care for patients at a community health center by providing screening and treatment of chronic hepatitis C infection within the patients' medical home with emphasis on improving screening rates for chronic hepatitis C.

*Study Design/Methods:* This project was a quality improvement project with a pre- and post-implementation analysis through retrospective chart review. To improve screening rates for all at-risk adults, changes to the existing EHR were implemented to alert nursing staff to perform a high-risk screening questionnaire for hepatitis C, and to notify providers to screen patients for hepatitis C based on the findings of the questionnaire. Furthermore, to increase providers' knowledge on screening and management of chronic hepatitis C virus, a face-to-face educational experience was provided with a pre- and post-activity questionnaire to assess provider knowledge and perception.

*Principal Findings and Quantitative/Qualitative Results:* In three clinics in which the screening intervention was initiated over a three-month period, screening for patients in the birth cohort (adults born from 1945 to 1965) increased from 13% to 34% and adults screened for high-risk behaviors for hepatitis C increased from 6.7% to 81.4%. Additionally, provider education, pre- and post-test results, showed increase in knowledge on screening and management of hepatitis C with all seven questions, testing general knowledge, showing statistically significant improvement in answers in post-testing with overall percent correct improving from 53% to 90% after provider education.

*Conclusions on Impact on Health Centers:* Increasing provider knowledge and making changes to existing electronic health record processes have shown to improve screening rates for chronic hepatitis C. Community health centers have the opportunity to improve the care provided to patients living with chronic hepatitis C virus. By increasing screening rates, patients who are in need of treatment from this potentially life-threatening disease can be properly identified and have an opportunity for a successful cure.

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CP45
Integration of Clinical Pharmacy Services in a Federally Qualified Health Center

Poster Type: Research

Primary Funding Source: This study was funded by the Nicholson Foundation, Institute for Medication Access and Compliance, Henry J. Austin Health Center, and Rutgers Ernest Mario school of Pharmacy.

Category: Expanding Access to Care and Other Services; Improving Care for Special Populations; Quality of Care and Quality Improvement; Workforce

Research Objectives: Considering the predicted shortage of providers, clinical pharmacists should be utilized to help manage patients with chronic medical conditions. The primary objective of the project was to demonstrate that the addition of the pharmacist improved healthcare outcomes for patients with diabetes. This presentation reviews interim results.

Study Design/Methods: Medicaid eligible patients diagnosed with Type 2 diabetes presenting with a glycosylated hemoglobin (A1C) concentration greater than 8% were randomized in a 1:1 ratio to either a control or an intervention arm. Patients in the control arm received care from their usual provider. Patients in the intervention arm received care from their usual provider and a pharmacist and they were required to complete a minimum of three visits with the pharmacist over 12 months. The pharmacists evaluated patients for medication therapy problems, made prescriptive changes together with the patient's healthcare provider, and recorded patient-centered guideline based interventions.

Principal Findings and Quantitative/Qualitative Results: 188 patients enrolled (93 control, 95 intervention) and 81 patients completed the 12-month evaluation. Mean A1C concentrations decreased from 10.31% to 8.38% (1.33%) in the intervention group and from 10.21% to 8.95% (1.34%) in the control group. More patients in the intervention group experienced an A1C reduction of least 1% (77.5% vs 61.0%) (p=0.017). Patients in the intervention group were more compliant with preventative care measures (P<0.05). Pharmacists identified 1570 medication therapy problems and received higher patient satisfaction scores than medical providers.

Conclusions on Impact on Health Centers: Providers were able to see more patients after clinical pharmacists joined the team of providers. Diabetes outcomes were equivalent, if not better, in the group treated by the pharmacists and patients were more satisfied with care. After the addition of the pharmacist, the health center's Unified Data System (UDS) measure for diabetes (A1C greater than 9%) improved from below to above the national and New Jersey state averages. The pharmacist's ability to identify medication therapy problems is likely to decrease the cost of medication related problems.

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CP46
Tobacco Intervention in Primary Care Treatment Opportunities for Providers

Poster Type: Research

Category: Quality of Care and Quality Improvement

Research Objectives: The Medical University of South Carolina (MUSC), with Matthew Carpenter, PhD as principal investigator, in partnership with the Eau Claire Cooperative Health Centers in Columbia, South Carolina, selected two clinical sites with the objectives to increase quit attempts and smoking cessation, and improve motivation and confidence to quit. This five-year comparative effectiveness study is funded by NIH/NIDA.

Study Design/Methods: Inclusion criteria: age 18 and older; daily cigarette smoker; primary care site patient. Nicotine Replacement treatment (NRT) sampling provided. Recruitment: smokers who are motivated to quit and unmotivated to quit. Twenty primary care clinics throughout South Carolina: 1160 smokers total, approximately 58 from each clinic; 10 clinics randomized to each intervention group (Usual care versus Usual care and NRT sampling); both groups receive a bag of materials to take home with them, but one group's bag will also contain NRT two-week supply. Outcome will be assessed centrally by MUSC research personnel by phone calls. Gift card mailed for participation.

Principal Findings and Quantitative/Qualitative Results: TIP TOP Principal Findings: A total of 130 patients were enrolled. When analyzing the preliminary results from the patient questionnaire, data showed that 72% of patients had health insurance; 88% were advised to quit smoking by a healthcare provider; 42% started smoking in their teen years; 50% made 1-3 attempts to quit smoking in their lifetimes; 61% stopped smoking for 1 day or longer at least 1-4 times when trying to quit smoking for good; and 2-3 months was the most frequent longest time patients stopped smoking.

Conclusions on Impact on Health Centers: The TIP TOP study is still enrolling patients, Eau Claire Cooperative Health Centers completed enrolling from two clinics on 2015 and this year two more clinics will begin enrollment. From 130 patients enrolled at the first two clinics: the majority (88%) were advised to quit smoking by their healthcare provider; 90% tried to quit smoking at least 1-3 times; and 68% think NRT improved their chance of quitting smoking.
A Team-Based Care Approach for Improving Colorectal Cancer Screening Rates at a Federally Qualified Health Center

Poster Type: Innovation

Category: Quality of Care and Quality Improvement

Issue or Challenge: Colorectal cancer (CRC) is the third most common cause of cancer and the second leading cause of cancer-related deaths in the United States. CRC screening is effective in detecting cases early and improving associated survival and mortality rates. However, significant disparities exist in CRC screening rates. Compared with non-Hispanic whites (62%), Latinos (47%) and, in particular, uninsured Latinos (19.9%) are much less likely to undergo CRC screening. In 2015, the nationwide CRC screening rate for FQHCs was 38%, and Esperanza Health Centers (a Latino-focused FQHC in Chicago) only screened 43% of its patients.

Description of Innovation: Esperanza employed four general strategies to improve its CRC screening rate in 2016. First, recognizing busy providers rarely have time to troubleshoot common barriers to screening, Esperanza redesigned its clinical care teams to add care coordinators to already existing medical assistant-provider dyads. Care coordinators contributed to CRC screening efforts in the following ways: providing detailed instruction to patients on how to perform fecal immunoassay (FIT) tests; conducting reminder calls for patients who did not complete ordered FIT tests in a timely fashion; mailing FIT tests to patients who were due to complete testing but had not yet had an appointment during 2016; and accompanying or setting up accompaniment for patients who did not have someone to go with them to a colonoscopy appointment.

Second, Esperanza created and began distributing monthly dashboards that included year-to-date CRC screening rates that updated clinical teams on their progress over the course of the calendar year. Third, Esperanza changed its quality incentive program to include financial bonuses for all care team members (medical assistants, care coordinators, and providers) on teams that achieved a goal of 60% patients screened for CRC. Esperanza also launched several friendly team-based competitions during 2016 aimed at generating attention and energy surrounding CRC screening, with prizes including activities such as a team trip to a professional basketball game. Finally, after transitioning electronic health records (EHRs) to Athena in December 2015, Esperanza leveraged Athena’s population health tool to provide teams with easily accessible lists of patients who had not completed CRC screening.

Impact or Result: Using the aforementioned strategies, Esperanza was able to increase its CRC screening rate from 43% in 2015 to 69% in 2016. Notably, all Adult Medicine care teams met the preset 2016 goal of 60% CRC screening, and one team even achieved a rate of 89%.

Replicating This Innovation: Esperanza’s experience in 2016 highlights several key steps in improving CRC screening rates. First, organizations must obtain buy-in with senior leadership to ensure appropriate resources are dedicated to the cause. Second, organizations should set an ambitious but realistic goal and invest in a mechanism to provide teams with regular reports on their performance. Third, organizations should consider financial incentives to motivate CRC screening performance. Next, organizations must ensure their EHR (or an add-on product) can serve as a population health tool to provide teams with lists of patients that have been seen during the calendar year, but have not performed CRC screening. Finally, FQHCs that serve the uninsured should recognize that efforts to increase CRC screening rates will likely rely heavily on FIT testing, and acknowledge that busy providers will need other team members to help with reminder calls to ensure FIT tests are returned.

Author(s): Carolina Rodriguez-Cook, Clinical Research Coordinator, Eau Claire Cooperative Health Centers

Presenter(s): Carolina Rodriguez-Cook
**Description of Innovation:** The purpose of this study is to screen and recall noncompliant patients at Lee Medical Arts Center. Patients will be screened for colon cancer, breast cancer, cervical cancer, hypertension, and pneumonia vaccinations. A list of noncompliant patients will be generated using Population Manager. These patients will be verified for noncompliance in eClinicalWorks electronic medical records. Noncompliant patients will be recalled for a navigational health visit which will focus primarily on the deficient screening measure.

Population Managers will reach out to the patients identified and attempt to bring them back into care with a “Nav Visit.” These visits will be short (15 minutes) and will focus on the areas the patients are deficient in.

**Impact or Result:** Our navigational visits were a huge success and they laid the groundwork for a CDC transformation project that we are currently working on. The visits helped a number of patients get screened for colorectal and cervical cancer. They also helped several patients lower their A1c and blood pressures. At the beginning of this study, many providers were not excited about seeing more patients as I am sure is normal across all FQHC’s— they feel overworked. But, when our “Nav Visits” came in they were well prepared and were actively participating in their own care which made the process much easier for our providers.

**Replicating This Innovation:** We believe the first step to getting started with “Nav Visits” is you must be able to identify who needs them. Without population managers and an analytical tool, like Population Manager, you are starting up a hill instead of down. To get started we believe that you should look for ways to use the resources around your FQHC. At AAPHC, we have a lot of medical students and students trying to get into medical school so we found a way to harness their need for research and our need for population management specialists.

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**Presenter(s):** James Hotz, William Grigg, Millie Foster, Hannah Bowe

**CP49**

**Mountain Comprehensive Health Corporation:**
**Making a Difference in Diabetes**

**Control**

**Poster Type:** Innovation

**Category:** Quality of Care and Quality Improvement

**Issue or Challenge:** Our region has a large population of patients with diabetes. Poverty, unemployment, low educational levels, and cultural influences are factors in the prevalence of this diagnosis. The mountains, although beautiful, make the communities more isolated, which translates into more travel time. In order to simply visit the nearest grocery store, many people have to drive approximately 30 miles. Travel time and lack of finances lead people to purchase less expensive, less healthy items that will keep longer, such as canned, packaged foods rather than healthier options. Our company works to improve patient education and address food insecurities.

**Description of Innovation:** Data validation is performed to ensure that patients truly have diabetes, and the diagnosis was not entered just because a lab test was ordered to screen for diabetes. Outside labs are added to the EHR so our records are complete. Patients that have a diagnosis of diabetes can be sent to the lab before they see the provider so the results are available during their visit. The appointments are flagged during pre-visit planning, and the check-in staff has been educated to look for diabetes diagnosis during check-in. A template has been developed to help us track the items that need to be completed. This template is populated during pre-visit planning. The providers are able to have a “one-click look” to see when the last A1c, microalbumin, foot exam, eye exam, depression screening, and oral exam were completed. They can see if the patient is a candidate for chronic care management, whether or not they have been offered a continuous glucose monitor, if they have completed a diabetes education class, or met with the dietitian. Each patient with diabetes is encouraged to have a dilated eye exam, oral exam, and foot exam completed each year. If they see a specialist, these records are added to their chart. If their A1c is elevated, we offer a continuous glucose monitor that assists the providers with medication adjustments. Classes are offered to teach patients about lifestyle modifications to help them stay as healthy as possible.

**Impact or Result:** Our controlled diabetes numbers have shown gradual improvement. The changes associated with diabetes take time in order to have sustained improvement. More diabetic eye exams and labs are being completed than in the past. The awareness of what is needed to monitor their blood sugars is improving. Patients with diabetes are more knowledgeable about what an “A1c” actually measures. Patients who are engaged, actively working to lower their blood sugars have had drastic decreases. Several patients with a hemoglobin A1c result of 13-14% dropped to 6-7% in less than twelve months. Patients have expressed appreciation at being able to improve their health. Many of the patients have shared that in the past they were told they had diabetes, maybe given a prescription, but not given any direction of what to do at that point. With the changes made, these patients now have an action plan.

**Replicating This Innovation:** The steps we have taken in our diabetes initiative have involved training all staff to look at the patient’s diagnosis and check to be sure actions are taken accordingly. There are two to three staff members that allocate a large portion of their time specifically to the diabetes population. These staff members analyze data, contact patients to provide education, offer opportunities to attend classes, place alerts in the electronic health record,
check that the needed items were completed and actions are taken according to the results. In healthcare, most of us already collect and analyze data as part of our processes, these changes make the data have an action attached. The dedicated staff that works on this project were existing employees who revised their workflow in order to work smarter to improve the health of our patients.

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**Presenter(s):** Cheryl Adams

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**CP50**

**Bringing Community Partners Together to Address Unspoken Realities of Chronic Disease, Diabetes, and Food Insecurity**

**Poster Type:** Innovation

**Category:** Achieving Savings; Expanding Access to Care and Other Services; Patient and Community Engagement; Public Health Crises; Quality of Care and Quality Improvement; Social Determinants of Health

**Issue or Challenge:** The low-income, uninsured, or underinsured patients served by PrimaryOne Health face numerous barriers to controlling chronic diseases such as diabetes, hypertension, and obesity. Nutrition and lifestyle modification play an important role in the control of these chronic diseases. When performed by a registered dietitian, medical nutrition therapy and lifestyle modification classes significantly improve outcomes. Access to healthy foods is a major barrier to making dietary changes and over 30% of PrimaryOne Health's patients screen positive for food insecurity. Studies show that food insecurity is linked to poorer diabetes outcomes, and inexpensive processed foods are often high in sodium and calories.

**Description of Innovation:** PrimaryOne Health's Integrated Nutrition Program addresses multiple barriers to adequate nutritional care by providing convenient access to medical nutrition therapy (MNT) by a registered dietitian or supervised dietetic intern, and connecting food insecure patients with healthy produce to treat their medical conditions. Patients with diabetes, hypertension, and obesity are able to see a registered dietitian or supervised dietetic intern at their primary care provider visits and receive MNT. By making the service available at the patients' primary care visit, patients are more likely to agree to the beneficial service. After the initial MNT visit, patients are able to receive follow-up nutrition care through additional one-on-one MNT visits (either on a separate day or at future primary care provider visits), weight management classes, diabetes classes, and/or cooking classes depending on the patients' needs.

To address access to healthy food, medical assistants, dietitians, and dietetic interns screen patients at least once annually for food insecurity at primary care provider visits by using the two-item, evidence-based questionnaire from Hager et al. Patients who identify as positive for food insecurity are given a Produce Prescription to get free fruits and vegetables once per week without an appointment from thirteen participating food pantries. A fax is sent to the Mid-Ohio Foodbank so that the patient can be entered into the PantryTrak client database shared by all of the participating pantries. Reports from PantryTrak are made available to PrimaryOne Health, so patients with unfilled prescriptions can be contacted and tracked for follow up.

**Impact or Result:** Food insecurity has a bidirectional relationship with diabetes and hypertension. During 2016, over 2,800 patients received medical nutrition therapy or class interventions with greater than 4,400 total patient encounters. Participating patients with diabetes, hypertension, and obesity saw improvements that were greater than standard care alone for the following metrics in 2015:

- Changes in HgbA1c
- 0.65% better than standard care at three months
- Changes in weight
- 14% of patients seen by a dietitian or intern reached a significant weight loss (5% body weight) compared to only 10% of the standard care group at six months
- Changes in blood pressure for uncontrolled hypertension (>140/90 mmHg)
- Blood pressures improved by an average of 2.7 mmHg (systolic) and 3.1 mmHg (diastolic) more in the dietitian group than standard care group at three months

Additionally, more than 1,400 patients have received a produce prescription from August 2016 to date.

**Replicating This Innovation:** To replicate in other organizations, start by researching reimbursement for dietitians in relation to the payer mix expected and/or identify alternative sources of funding. Then reach out to potential community partners – local food banks with initiatives to improve health and universities with a dietetic internship program. If you are able to identify partners and funding, identify a champion within executive management to legitimize the value of your proposal. Hire a registered dietitian with outpatient counseling skills, program management experience, and an assertive, proactive attitude. Present to staff, especially referring primary care providers, about the value of a registered dietitian and evidence for improved patient outcomes. In the clinics, have the dietitian within very close proximity to clinic rooms for ease of access. Consider creating a standing order for medical nutrition therapy that will allow the dietitian freedom to see patients who are waiting for their primary care provider.

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**Presenter(s):** Parminder Bajwa, Buhari Mohammed
**CP51**

**Linking Clinical Care With Community Supports**

**Poster Type:** Innovation

**Category:** Expanding Access to Care and Other Services; Quality of Care and Quality Improvement; Social Determinants of Health

**Issue or Challenge:** The Michigan Primary Care Association (MPCA) and 16 community health centers launched the Linking Clinical Care with Community Supports (Linkages) initiative in 2015, building upon the work of health centers in implementing interdisciplinary team-based approaches by incorporating community health workers (CHWs). CHWs have a significant amount of training and expertise, particularly in addressing the challenging pressures impacting people's health and quality of life. The impacts of social determinants on healthy behaviors have repercussions for patients living with already challenging health circumstances. MPCA's Linkages program sought to link the comprehensive clinical care health centers provide with community-based services and social supports.

**Description of Innovation:** Participating health centers identified care teams whose CHWs have a focus population from one of three patient groups: pregnant women, children with asthma, and older adults with one or more chronic condition. Health centers hired CHWs within the first month of the grant period, and MPCA, in partnership with the Michigan Community Health Worker Alliance (MiCHWA), provided CHWs with training to equip them to work with primary care teams and to effectively educate and motivate patients. In addition to CHW core competencies, this training included motivational interviewing, patient health education, and more. These teams worked together to link their patients with clinical care, community-based interventions and supports, as well as encourage patient-centered healthcare decision-making.

CHWs gathered patient consent to participate in the Linkages project and completed the Protocol for Responding to and Assessing Patients’ Risks, and Experiences (PRAPARE) assessment and the Patient Activation Measure (PAM) within seven days of patient enrollment. The PRAPARE tool identified the patient's areas of physical and social needs and prompted the CHW to make referrals in areas such as housing, government assistance, mental health, and more. The PAM assessment provided a level of activation (1-4) ranging from “disengaged and overwhelmed” to “maintaining behaviors and pushing further.” PAM scores provided CHWs with a numerical value attributed to a patient's stability and independence. Ongoing support to CHWs and care team members was provided by MPCA with biweekly conference calls used to provide updates and discuss any questions or challenges staff may have.

**Impact or Result:** The success of the project is based on five major evaluative domains: health outcomes, patient engagement and satisfaction, social needs and health disparities impacts, healthcare cost savings, and interdisciplinary team sustainability. While the Linkages project final evaluation is currently underway, the results following year one of the project showed a number of promising outcomes. A result of the integrated CHW model has demonstrated a reduction in patient no-show rates in health centers. CHWs linking patients to transportation resources and providing reminder calls to patients contributed to the decrease in no-shows.

The Linkages initiative was a practice transformation initiative that resulted in an integrated and holistic healthcare model enabling care team members to practice at the top of their scope. The impact of providing this level of support to patients resulted in health centers sustaining the CHW positions after the project ended, and often increasing the number of CHWs on staff.

**Replicating This Innovation:** MPCA would be interested in providing mentorships and partnerships with different organizations interested in implementing an integrated CHW model. MPCA has currently partnered with several state primary care associations to share workflows/lessons learned, develop training curriculum, and explore future CHW-focused initiatives.

Additionally, MPCA will publish a final evaluation report in 2017 highlighting the program objectives, implementation steps, and successes and challenges related to the integrated CHW model of care. This report will include data describing the impact that the Linkages initiative had on health outcomes and cost reductions, utilizing clinical and non-clinical data as well as hospital utilization patterns.

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**Presenter(s):** Julie Tatko

**CP52**

**Integration of a Home Blood Pressure Monitoring Program in Hypertension Management at a Community Health Center**

**Poster Type:** Innovation

**Category:** Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Workforce

**Issue or Challenge:** White coat syndrome, masked hypertension (HTN), and poor technique may produce inaccurate office-based blood pressure (BP) readings and lead to overdiagnosis and overtreatment with antihypertensive agents. National and international HTN guidelines, along with the U.S. Preventative Services Task Force, recommend using home BP monitoring in conjunction with office readings for HTN diagnostic and/or treatment evaluation. To ensure accurate diagnosis and appropriate medication management, our community health center's Adult Medicine department integrated a loaner home BP monitoring program with office-based HTN management.
**Description of Innovation:** The loaner home BP monitoring program is a creative innovation to support primary care providers in their decision-making while engaging patients in their health monitoring. Seeing that primary care providers are often faced with limited time and competing priorities, our clinical pharmacist sought to pilot a home lending BP monitoring program to collect blood pressure readings that better reflect a patient’s actual condition. Having the more accurate readings, followed up in a later appointment, allowed providers to maximize their clinical judgment and adjust treatment options accordingly. This initiative began with our clinical pharmacist, who then trained pharmacy students on how to complete pharmacy checks to ensure patients at minimum were getting refills of their medications. During this pilot, Adult Medicine providers appreciated the utility of the home monitoring program for their patients’ care and the program expanded and became embedded as part of our clinical management.

**Impact or Result:** Over the first year of the program, 75 patients were referred for either medication management evaluation (n=41) or HTN diagnosis confirmation (n=34). For those patients referred for medication management evaluation, roughly half (n=20) had some clinical action taken and roughly half (n=21) had no action taken. Of the 34 patients referred for HTN diagnosis confirmation, 23 (68%) had home BP readings averaging less than 135/85 mmHg (the recommended target BP goal for home monitoring) resulting in no formal diagnosis of hypertension and no medication prescribed. This was particularly pronounced in those patients with an office BP goal of <150/90 mmHg, a relatively older group. This data suggests that integrating home BP monitoring with office-based HTN management is clinically important and may have substantial impact in ensuring the accuracy of diagnosis and appropriateness of medication use.

**Replicating This Innovation:** Important features to any home blood pressure loaner program includes: using validated meters (preferable with an AC adapter rather than batteries); direct patient instruction on how to use and document multiple readings over several days; ensuring patient engagement through disease and results education; and defining a predetermined method how the results are relayed to the provider for evaluation.

We have found that having separate office visits from the primary care provider and defined clinical staff to facilitate the program has resulted in a sustainable means for the program to be successful, allowing us to expand from Adult Medicine to Family Medicine.

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**Social Determinants of Health**

**CP53**

**Assessing Food Insecurity in the West Side Neighborhood of Chicago**

**Poster Type:** Research

**Category:** Improving Care for Special Populations; Quality of Care and Quality Improvement; Social Determinants of Health

**Research Objectives:** This study aims to address the need of food insecurity in the West Side neighborhood of Chicago. We are conducting a needs assessment of the community to determine, qualitatively and quantitatively, the degree of food scarcity in the neighborhood as well as the food scarcity status of patients visiting our health center.

**Study Design/Methods:** Patients visiting the FQHC over a three-month period were assessed for food insecurity using a two-question tool. An in-depth survey was also completed with patients during the second phase of the study to determine whether the two-question tool was effective in detecting food insecurity. Additionally, the community was canvassed to find supermarkets that carry a standard list of items considered to be food staple items and their cost. Further, investigators met with the West Side Community Alliance, a group of community members interested in the betterment of the neighborhood, to learn about barriers to food access.

**Principal Findings and Quantitative/Qualitative Results:**
Thus far, the two-question tool used by the medical assistants has yielded few positive results. Considering the known high rate of food insecurity in the neighborhood, an in-depth survey was developed to ask further questions regarding food access. This survey is currently underway. Community canvassing is underway as well. This process will allow providers to determine if/where a supermarket with food staple items exists in order to provide this information to patients visiting the FQHC. A meeting with the West Side Community Alliance is currently scheduled.

**Conclusions on Impact on Health Centers:** Results ascertained thus far with the two-question assessment tool point to a discrepancy with current city data. We expect to get more information regarding this discrepancy with the in-depth survey tool and community canvassing. This will allow us to better understand barriers to health and wellness for the patients we serve. With the data that is obtained, recommendations will be made to allow the Austin Health Center to be more responsive to patient and community members’ needs.

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**Presenter(s):** Sumeet Singh
Addressing Patients’ Social and Economic Needs in Medical Care Settings: A Systematic Review of the Literature

Poster Type: Research

Primary Funding Source: Robert Wood Johnson Foundation

Category: Social Determinants of Health

Research Objectives: Healthcare systems are increasingly experimenting with interventions to address patients’ social and economic needs. To better understand the impacts of these activities, we undertook a qualitative systematic literature review to examine how often, how, and how well interventions bridging social and medical care have been evaluated.

Study Design/Methods: The review included literature from PubMed, published in English, between January 2000 and February 2017 that described evaluations of interventions specifically designed to address patients’ basic resource needs in the context of medical care delivery. Additional studies were identified by hand searching bibliographies of retrieved articles and consulting local experts. To be included, an evaluation had to be based in the U.S.; address at least one social determinant of health, e.g., housing, employment, or food insecurity; and be integrated with the medical care delivery system.

Principal Findings and Quantitative/Qualitative Results: Screening of 4,965 articles identified 67 studies of 37 programs addressing social needs. Interventions targeted a broad range of social needs and populations. Forty studies involved non-experimental designs. There was wide heterogeneity in outcome measures selected. More studies reported findings associated with process (69%) or SDH (48%) outcomes than health (30%) or healthcare utilization or cost (27%) outcomes. Studies reporting health, utilization, or cost outcomes reported mixed results.

Conclusions on Impact on Health Centers: Healthcare systems increasingly incorporate programs to address patients’ social and economic needs in the context of care delivery. But evaluations of these programs to date are heavily weighted towards process and social outcomes and are often limited by poor study quality. Higher quality research that includes common health and healthcare utilization outcomes would advance our understanding of effective interventions in this rapidly expanding field.

Author(s): Holly Wing, MA, Senior Clinical Research Coordinator, University of California San Francisco

Presenter(s): Holly Wing

Understanding the Community-Level Social Determinants of Health of Community Health Center Patients

Poster Type: Research

Primary Funding Source: Patient-Centered Outcomes Research Institute (PCORI)

Category: Social Determinants of Health

Research Objectives: Social determinants of health (SDH), including the economic, social, and environmental characteristics of communities where people live, affect a wide range of health outcomes and risks. This study describes the community-level SDH characteristics of patients receiving care in community health centers, as compared with the general U.S. population.

Study Design/Methods: We use data from OCHIN, a health information and innovation network, serving hundreds of organizations comprised of over 10,000 clinicians nationwide, focusing primarily on safety-net community health centers (CHCs). Geocoded community-level SDH data (from publicly available sources) were linked to individual patient EHR data in the OCHIN research data warehouse, using information on patient address. Community-level SDH measures for OCHIN patients were compared to community-level SDH measures for those in the general U.S. population. Analyses were limited to established patients at OCHIN CHCs who had a primary care visit in 2015 (343 clinics in 17 states).

Principal Findings and Quantitative/Qualitative Results: Results indicate that a higher proportion of OCHIN CHC patients live in socially vulnerable communities. For example, 49.6% lived in communities with high social deprivation scores, 44.2% lived in communities with high poverty rates, 43.5% lived in communities with high unemployment rates, and 40.7% lived in communities with low median household incomes (high and low are defined as falling in the top and bottom 25% of the U.S. population, respectively). Preliminary analyses suggest a relationship between community-level SDH characteristics and quality of care measures, such as percent of diabetics in poor control.

Conclusions on Impact on Health Centers: There is mounting evidence that patient social factors may have more to do with quality of care than individual provider performance. It is imperative that health systems use available data on patient clinical and social characteristics to better understand how these factors impact the delivery of care reflected in current quality metrics. The availability of linked SDH and clinical data in the OCHIN research data warehouse will enable further investigation and the development of improved methods to account for the impact of SDH on measures of clinic performance and quality.

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Presenter(s): Erika Cottrell
CP56

Creating a Social Needs Program in a Federally Qualified Neighborhood Health Center

Poster Type: Innovation

Category: Expanding Access to Care and Other Services; Social Determinants of Health

Issue or Challenge: We developed a social needs program as part of our mission to address patients’ basic resource needs as a standard part of high-quality care. Unaddressed social needs have a clear adverse effect on patient health. Furthermore, compared to children from more advantaged backgrounds, children raised in poverty experience poorer health and commonly face unmet basic needs (food, housing, utilities etc.) (1-4). Serving a predominantly low-income urban community, we felt a moral imperative to create a system that addressed these issues, as we believe that families’ social and behavioral needs deserve the same degree of attention as their medical needs.

Description of Innovation: The original program model was established in 2010 in the pediatrics clinic in partnership with Health Leads. A program manager and cohort of college student interns provide patients with resource referrals for social needs. Families receive weekly follow-up until their needs are met. In 2012, we began screening all pediatric families for social needs and discovered approximately 45% had a social need. We use Health Leads’ Reach technology: A case management software and resource database. In 2014, we expanded the program across all health center clinics and hired community health workers (CHWs). The CHWs were full-time, multilingual employees rooted in the communities served by Dimock and were experienced in the field. Goals of this capacity building process were to provide more consistency of care and improve engagement with existing clinic teams. The planning and development processes took eight months and implementation six weeks. A working committee was formed with Health Leads and Dimock staff including a project and clinic lead from each clinic. The working committee met monthly during planning and development and biweekly throughout implementation. Major steps were delineating the program scope for each clinic and creating workflows which best supported these goals. This included outlining the social needs priorities in each clinic and staffing and workflows for each clinic. Assigning responsibilities to existing staff and creating clear roles for new employees on the resource team proved vital. During implementation, the current program manager of the resource team and a Health Leads staff member were available to answer questions.

Impact or Result: Compared to 2014, in the year following program expansion, Dimock served 73% (466) more clients, closed 96.77% (240) more needs successfully, 51.6% (113) more needs as equipped (able to continue without follow-up or on a waiting list), and gave resource information without follow-up for 478.48% (378) more needs (RRR). These numbers increased in 2016. Findings from 2013 indicate that families receiving the lowest touch version of our program (RRR) experience improved outcomes compared to families who get no intervention (5). By focusing on transportation and health needs (insurance, prescription assistance, etc.) the Adult Medicine clinic expanded access to care. In 2015, we connected 147 more patients to Medicaid transportation compared to 9 in 2014. Our program also enabled our Masters-level social workers to provide more billable therapy. In 2011, the clinical social workers studied had a 169% increase in reimbursable therapeutic services.

Replicating This Innovation: It is essential that clinical and administrative leadership have buy-in to this model. Once that is accomplished, organizations can begin by identifying clinic leaders and staff to take on the role of project manager. Furthermore, it would be beneficial to form a working committee dedicated to identifying project goals, desired outcomes, and program design that complements current workflow. It is also important to run through workflow changes with all staff members as well as ensure new staff hired for your resource team are well trained and capable of assisting families. Do not do this work in isolation—talk to other community health centers who have implemented similar programs. By working with other health centers, you can avoid mistakes and get a more detailed understanding of different models. Health Leads has created a learning collaborative and continues to partner with health systems to assist with program implementation.

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Presenter(s): Rachael Edelson

CP57

La Clínica’s Transitions Clinic: A Comprehensive Clinic Serving the Health and Psychosocial Needs of the Re-Entry Population

Poster Type: Innovation

Primary Funding Source: Partnership HealthPlan of California Local Innovation Grants on Social Determinants of Health

Category: Social Determinants of Health

Issue or Challenge: La Clínica’s Transitions Clinic addresses the unmet health and psychosocial needs of formerly incarcerated patients in Vallejo, California. The re-entry population faces higher burdens of chronic disease, mental illness, and substance misuse than the general population. For example, 80% of released prisoners in the United States have chronic medical, psychiatric, and/or substance abuse issues. Drug abuse, HIV/AIDS, and hepatitis C also disproportionately affect prisoners. While access to primary care is essential to treating this disease burden, social determinants such as housing, employment, food, and transportation are just as – if not more – important in the road to recovery and re-entry.

Description of Innovation: The Transitions Clinic is a comprehensive, innovative solution to address the health
and psychosocial needs of the re-entry population via a coordinated system of care. The La Clinica Transitions Clinic provides a patient-centered medical home for chronically-ill individuals with a recent history of incarceration. The Clinic is held weekly, where patients are seen for preventive and chronic disease management services by their Transitions Clinic care team: a medical provider, medical assistant, integrated behavioral health clinician, and community health worker (CHW).

The Transitions Clinic provides not only primary care, but also outreach to newly-released individuals, assistance with insurance enrollment and health system navigation, health promotion, referrals to behavioral health services, social services, substance abuse treatment, and specialty healthcare in the community. The peer CHW facilitates the majority of these services, providing basic case management to help address the upstream determinants of health through referrals and coordination with agencies providing housing, legal, food, and employment services. The CHW also makes available to patients emergency food assistance vouchers, medication assistance, and transportation vouchers.

Finally, the Transitions Clinic has served as a pilot site for collecting patient data around social determinants of health (SDH) via the PRAPARE tool. The CHW collects PRAPARE data in the course of her intake assessments with patients, and after having been the first La Clinica staff member to utilize the PRAPARE template in La Clinica’s electronic health record, is now entering the patient data electronically.

**Impact or Result:** The Transitions Clinic has been operating for six months and has served 29 patients to date. La Clinica will be monitoring self-rated health, food, employment and housing status, and emergency room use over the next year to evaluate the change in health and psychosocial status. At baseline, 50% of patients have reported their self-rated health as fair or poor, while 50% have rated good, very good, or excellent health. With regard to SDH collected on the PRAPARE tool, 75% of patients have reported that they have housing, while 25% do not have housing or are fearful of losing their housing. The CHW is therefore connecting patients to local housing resources and continuing to search for additional resources. Finally, 92% of patients have reported that they are able to obtain food, but many have accepted referrals to the local food bank for additional support.

**Replicating This Innovation:** La Clinica’s Transitions Clinic was modeled off of the program established by the Transitions Clinic Network. There are at least 14 clinics nationwide implementing a Transitions Clinic, which is a testament to the fact that this innovative model is easily replicated. La Clinica has worked closely with the Transitions Clinic Network leadership team in developing and implementing the Clinic; other health centers that are interested in establishing their own Transitions Clinic would be able to access the Network’s resources as well. This is a relatively low-cost program for serving a very high-need population, as the Community Health Worker is the only new position added to clinical staffing structure.

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**Presenter(s):** Marianne Bruno

**CP58**

**Building Hospital-Community Partnerships to Reduce Smoking: Challenges and Opportunities**

**Poster Type:** Innovation

**Category:** Social Determinants of Health

**Issue or Challenge:** Under the Affordable Care Act, non-profit hospitals are required to implement Community Health Needs Assessments (CHNA) and strategies every three years to maintain their tax-exempt status. To meet this requirement, New York State hospitals are creating Community Service Plans (CSP) that align with the statewide Prevention Agenda aim at improving population health. New York University Langone Medical Center (NYULMC) developed a CSP to promote community engagement, improve coordination of hospital and community health improvement efforts, and encourage adoption of evidence-based interventions. The CSP partners have identified challenges and opportunities in building and sustaining hospital-community collaborations.

**Description of Innovation:** Since 2013, NYULMC has continuously engaged diverse stakeholders, with a focus on medically-underserved residents, to assess community needs; set priorities; develop, design, and implement programs; and share progress and results. The CSP is focused on neighborhoods with concentrated pockets of poverty and groups that experience disparities in many health outcomes. NYULMC supports community partners with direct grants, and through the Department of Population Health, brings wide-ranging expertise to the CSP, such as comparative effectiveness research, biostatistics, epidemiology, health behavioral change, and science of healthcare delivery.

One key partner is the Charles B. Wang Community Health Center (CBWCHC), an FQHC with more than 45 years of experience serving Asian Americans. CBWCHC’s expertise includes delivering culturally effective services, developing innovative community programs, and reaching immigrants and other hard-to-serve populations. NYULMC and CBWCHC collaborate in the smoking cessation priority area in the CSP. While New York City has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 14.3% in 2015, the benefits have not reached Asian American immigrant populations. Asian American men are the only group in New York City that saw an increase in smoking rate from 19.6% in 2002 to 25.4% in 2015 [1]. Through the CSP, a multisector Asian American Tobacco Free Partnership has grown steadily since 2013. The partners conduct bilingual education campaigns on health risks related to smoking and second hand smoke, promote access to culturally appropriate cessation services through trained navigators, and support community physicians in cessation counseling, treatment, and referrals.
Impact or Result: CBWCHC developed a bi-lingual smoking cessation coaching program which offers counseling, Nicotine Replacement Therapy, and personalized follow-up to support changes in smoking behaviors. Since November 2015, 479 smokers have been referred by providers to the health coach, 241 (50%) received counseling, 34% (81/241) quit smoking for at least one day, and 55% (132/241) 72% (43/60) reduced their smoking. CBWCHC and NVULMC completed a street intercept survey with 250 community residents to assess their knowledge and use of tobacco treatment services. In addition, the community coalition meets on a quarterly basis to monitor progress towards achieving a smoke-free community. Plans are also being developed to engage public housing tenants as New York City moves forward to implement the recently enacted federal ban on smoking in public housing.

Replicating This Innovation: One of the key elements of replicating this innovation is the importance of identifying leadership from the academic institution that understands what it takes to work with community-based organizations and the academic institution’s willingness to invest in a long-term partnership. When members of the CSP Coordinating Council were asked to identify key elements that have allowed for a successful academic-community partnership, many members credited the director of the Community Service Plan’s deep commitment to partnership which has resulted in collaborating across disciplines, departments, and institutions, and investing the time in understanding and adapting to cross-cultural issues as the primary ingredients of success.

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Presenter(s): Regina Lee

CP59

Multi-Sector Strategies to RAISE Community Health

Poster Type: Innovation

Category: Social Determinants of Health

Issue or Challenge: Despite the “model minority” perception that Asian Americans and Pacific Islanders (AAPIs) are healthier than mainstream Americans, preventable chronic diseases like cardiovascular disease (CVD) and diabetes impact AAPIs. In 2010, approximately 33% of AAPI deaths nationally were CVD-related, and 9.1% of Asians had diabetes compared to 7.6% of Whites. Given this, Asian Services in Action (ASIA) developed RAISE (Reaching Asian Americans through Innovative and Supportive Engagement), which engaged a multi-sector coalition to identify policies, systems, and environmental (PSE) improvements to eliminate health disparities and empower AAPIs to use high-impact population-wide strategies to reduce barriers to healthy nutrition and physical activity.

Description of Innovation: ASIA’s alignment of public health initiatives to partner mission and visions brings in the innovation. Recent public health initiatives include PSE strategies with the aim of improving community health. These high-impact, population-wide strategies provide opportunities for multi-sector coalitions to engage and inform the implementation process to reach underserved communities like AAPIs in Cleveland, Ohio. As the public health landscape shifts towards improving community health through PSE strategies, it is vital that multi-sector coalitions are included to potentially have the greatest impact in health overall and to increase community buy-in and engagement.

Through investing in and strengthening multi-sector partnerships, providing technical assistance and communications training, and cultural tailoring of interventions, RAISE was able to reach approximately 49,000 community members with their chronic disease prevention and healthy nutrition and physical activity interventions. ASIA engaged existing and new partners to join the RAISE coalition and established memorandum of understanding. RAISE conducted a needs assessment and policy scan using the Community Health Assessment and Group Evaluation (CHANGE) tool with their coalition. Through coalition meetings and capacity building trainings, ASIA worked with each coalition member to create a community action plan and to build their capacity to culturally tailor (i.e., Tai chi, traditional dances) and implement PSE intervention in order to increase access to physical activity. Capacity building included communications training on framing and messaging to key stakeholders and sustainability. Coalition members disseminated their strategies on social media, ethnic media, and co-hosted a RAISE Summit and shared their accomplishments to attendees.

Impact or Result: ASIA remains committed to the value of health equity and promoting a shared learning community across all the organizations with whom they work. Through investing in and strengthening multi-sector partnerships and providing technical assistance and communications training, RAISE was able to reach approximately 49,000 community members with their chronic disease prevention and healthy nutrition and physical activity interventions. All of RAISE coalition members are working to create joint or shared use agreements with local cultural, community centers, schools, faith-based facilities, recreational centers, businesses, and parks. A joint use agreement is a formal agreement between two separate entities setting forth the terms and conditions for the shared use of public property. Joint and shared use agreements create additional spaces for communities to access and use for physical activity and to strengthen connections to the community’s social network and gathering. RAISE was able to secure seven agreements in Cleveland.

Replicating This Innovation: ASIA used a process to develop the multi-sector coalition, which included engagements, assessments, and implementation. ASIA engaged new and strengthened previous partnerships to become involved in RAISE. Using the CHANGE process mentioned above, the coalition conducted needs assessments and policy scans. ASIA communicated the coalition’s purpose, personalized each coalition member’s value, and shared how their organization could build their own capacity through their involvement.
Formal memoranda of understanding were established, and some funding was provided to each organization to support their strategy and participate in the coalition meetings. The framework of multi-sector coalitions can be duplicated among various public health priorities and especially among vulnerable racial and ethnic groups to improve the effectiveness of health initiatives through interagency partnership and cooperation. By pooling resources, talents, and strategies from a broad range of actors, each of these sectors can more effectively carry out its responsibilities as they affect population health.

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**Presenter(s):** Cathy Vue, Ashley Choi, Mieko Smith

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**CP60**

**The Community-Centered Health Home Model: Mobilizing Health Centers to Improve Community Determinants**

**Poster Type:** Innovation

**Primary Funding Source:** The Community-Centered Health Homes Demonstration Project is supported by the Gulf Region Health Outreach Program. The Outreach Program was developed jointly by BP and the Plaintiffs’ Steering Committee as part of the Deepwater Horizon Medical Benefits Class Action Settlement.

**Category:** Patient and Community Engagement; Social Determinants of Health

**Issue or Challenge:** As the healthcare system shifts from volume to value, its role in addressing community-level determinants of health is expanding, opening opportunities for more strategic community partnerships. The Community-Centered Health Home (CCHH) model, developed by Prevention Institute, provides a framework for healthcare organizations to engage in improving upstream community conditions that impact health. The model calls on healthcare institutions in the past. To build trust, FQHCs had to show FQHCs found that the community had been let down by larger partnerships. During the Demonstration Project, several the community's goals will go a long way in building strong community-level change; FQHCs must listen to community priorities and allow community partners to lead the way; and (3) community prioritization and strategic planning; and (3) coordinate with partners to put the community change agenda into action. The model asserts that by stepping outside of the facility walls to address community environments, healthcare institutions can contribute to improvements in population health outcomes, build more trusting relationships with their communities, and bring joy to clinicians and staff who are often frustrated by the external factors that interfere with their patients’ health.

**Impact or Result:** Participating FQHCs have: gained knowledge and skills to better understand and address social determinants and community prevention; successfully implemented core elements of the CCHH model; developed new and deepened existing community partnerships, and engaged in internal and external activities to implement the inquiry, analysis, and action elements of the model.

**Replicating This Innovation:** There are many steps that FQHCs or other healthcare organizations can take to implement CCHH. An important starting point is to learn about the social determinants of health and how they impact health behaviors, healthcare utilization, and population health outcomes. Another critical step is participating in community coalition or workgroup meetings. Any initiative that an FQHC can take to demonstrate that they are willing and able to contribute to the community’s goals will go a long way in building strong partnerships. During the Demonstration Project, several FQHCs found that the community had been let down by larger institutions in the past. To build trust, FQHCs had to show they were committed to a long-term partnership and would not disappear when funds dried up. Lastly, listening to the community’s needs and priorities is a helpful place to start when trying to decide what problems to address first.
CP61

Integrating Civil Legal Aid Into Nurse-Managed Health Centers

Poster Type: Innovation

Primary Funding Source: Kresge

Category: Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Social Determinants of Health

Issue or Challenge: More than 250 nurse-managed health centers (NMHCs) operate throughout the U.S., largely in medically underserved areas, and annually reach more than 1.5 million patients. Nurse practitioner (NP) leaders of NMHCs are trained at the graduate-level to identify, diagnose, and treat physical and behavioral health conditions by considering and evaluating social determinants of health impacting health and well-being. Research demonstrates consistently high outcomes for NP-led care across population and wellness measures.

Description of Innovation: Funded by the Kresge Foundation, the Nurse-led Medical-Legal Partnership Initiative stemmed from a fundamental proposition that the comprehensive, patient-centered models of care championed by nurse-led health settings create a ready-made environment for the medical-legal partnership (MLP) approach to thrive. MLPs align well within a patient-centered nurse-led model to identify and treat health-harming legal needs, facilitate coordination of care, and achieve quality improvement and data tracking using EMR and other technologies. The aim of the Nurse-led MLP Initiative was to integrate and enhance the MLP approach within NMHCs.

Impact or Result: Johnson City Community Health Center @ ETSU; legal partner: Tennessee Justice Center (TJC). Priority legal need of patient population-- child health insurance strategy for sustainability: measure financial return on investment through changes in uninsured.

Outcomes: 816 patients were screened for assistance; 433 applications for insurance were submitted; 383 enrolled in insurance; 33 appeals filed for MLP clients; 22 referred to TJC for representation. Interventions, process, and training through the MLP produced $119,013 in reimbursement for insured versus uninsured visits during the project period. As of May 2016, 16 other NMHCs expressed an interest in or started integrating civil legal aid into their health settings.

Replicating This Innovation: The “Addressing Civil Legal Needs of Nurse-Led Care” issue brief is a great step-by-step guide to assess readiness and necessary infrastructure and funding to support onboarding of a MLP.

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Presenter(s): Kristine Gonnella

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CP62

Leveraging HIT for Evidence-Based Pediatric BP Management in the Safety Net

Poster Type: Research

Primary Funding Source: Agency for Healthcare Quality and Research

Category: Technological Solutions and Tools to Improve Care and Population Health Management

Research Objectives: (1) Leverage EHRs data to determine baseline rates of undiagnosed pediatric hypertension in a CHC. (2) Develop and implement an EHRs-based pediatric blood pressure clinical decision support (CDS) tool integrating evidence-based medicine and provider needs for optimized use of HIT. (3) Determine rates of undiagnosed hypertension after implementing CDS.

Study Design/Methods: Qualitative data was collected on desired features of a pediatric blood pressure interpretation CDS tool. The Five Rights Principles of Clinical Informatics were employed to build CDS responsive to end-users of the EHRs through integration of themes elicited from interviews of pediatric and family medicine providers. Formal end-user testing occurred to drive further improvements to the CDS tool before implementation in the EHRs environment. Data was analyzed after introducing the new CDS tool in the EHRs environment to determine change from baseline in appropriate hypertension diagnosis.

Principal Findings and Quantitative/Qualitative Results: Baseline data on accuracy of blood pressure assessment indicated significant gaps in accurate diagnosis of pediatric hypertension. Through an iterative process including usability testing, an evidence-based CDS tool for blood pressure interpretation was deployed in the EHRs environment. Usability testing revealed that clinicians desired a tool that
was not intrusive or coercive and provides evidence-based guidance, while preserving the ability to make and record a diagnosis of hypertension. Core components of the CDS included: assessment of present blood pressure and three previous values with percentiles to enhance diagnostic value; inclusion of patient education materials; and clinical management guidance.

**Conclusions on Impact on Health Centers:** Low-income children of racial and ethnic minorities are at higher risk for developing cardiovascular disease. Leveraging technology in real-world clinical practice should build upon a framework that includes the right information, to the right individuals, in the right intervention format, through the right channel, at the right time in workflow. These principles applied to the implementation of an EHRs CDS tool can yield a successful point-of-care instrument to support blood pressure management. Developing CDS that is patient and provider-centered has the potential to improve prevention, diagnosis, and management of elevated blood pressure in vulnerable children.

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**Presenter(s):** Nivedita Mohanty

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**CP63**

**Using Population Managers to Increase Screening Rates for Breast, Cervical, and Colorectal Cancer in a Southwest Georgia FQHC**

**Poster Type:** Research

**Primary Funding Source:** Albany Area Primary Health Care

**Category:** Achieving Savings; Expanding Access to Care and Other Services; Improving Care for Special Populations; Patient and Community Engagement; Quality of Care and Quality Improvement; Social Determinants of Health; Technological Solutions and Tools to Improve Care and Population Health Management

**Research Objectives:** The objective for this study is to increase compliance with current preventative screening protocols through strategic outreach to noncompliant patients identified using a population manager software. In addition, patient charts are reviewed and corrected for previous documentation errors.

**Study Design/Methods:** The analytical tool, along with the position of a population manager, was employed in an FQHC in Albany, Georgia, Albany Area Primary Health Care (AAPHC), in four of eight primary care clinics. The analytical tool was used to screen current patients, patients lost to follow-up, and new patients to ensure compliance with preventative screening measures. During chart auditing of scheduled patients, the population manager corrected documentation errors and alerted providers of preventive screening measures to address with patients. For unscheduled patients, charts were audited to ensure documentation accuracy and recall action lists were generated to schedule appointments.

**Principal Findings and Quantitative/Qualitative Results:** During the two month research period there was significant growth in test clinics when compared to control clinics. In at least one clinic, the breast cancer screening rate increased by 21% (27% to 48%), the cervical cancer screening rate increased by 8% (61% to 69%), and the colorectal cancer screening rate increased by 17% (72% to 89%).

**Conclusions on Impact on Health Centers:** Based on the results of this study, it is hypothesized that by implementing population managers across the AAPHC network of clinics, it will lead to nearly an 80% screening rate for the three fields measured above. With an 80% colorectal screening rate nationwide, the American Cancer Society states that nearly 203,000 deaths will be prevented from 2013 to 2030, and in Georgia an 80% screening rate will save 5,617 lives. While barriers to cancer screening exist, an 80% cancer screening rate can be achieved in Southwest Georgia by employing the model in this study.

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**Presenter(s):** James Hotz, William Grigg, Millie Foster, Hannah Bowe

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**CP64**

**A Further Look at Health Information Technology Tools to Facilitate Health Insurance Support**

**Poster Type:** Research

**Primary Funding Source:** National Cancer Institute: R01 CA181452

**Category:** Technological Solutions and Tools to Improve Care and Population Health Management

**Research Objectives:** Improve continuity of health insurance coverage and receipt of needed preventive care among community health center (CHC) patients by developing new health insurance support tools (IST) within the electronic health record (EHR).

**Study Design/Methods:** We utilized a user-centered design process to understand clinics’ needs and develop the IST. We are using a hybrid implementation-effectiveness trial design to evaluate the tools. Eligible CHC clinics were randomized to: IST + training (Arm I), or IST + training + implementation support (Arm II). A propensity score-matched control group
of clinics was selected as a comparison group. Quantitative analyses will use EHR and Medicaid data to assess tools’ effectiveness. Qualitative data are being collected to evaluate the implementation process and identify facilitators and barriers to tool adoption.

**Principal Findings and Quantitative/Qualitative Results:**
We developed and implemented EHR-based IST designed for use by the CHCs’ staff assisting patients with insurance enrollment. Implementation support to clinics, data collection regarding tool utilization, insurance enrollment, and preventive care are ongoing. Our ongoing tool use tracking and qualitative interviews suggest: (1) tool use is increasing in some participating clinics; (2) tools are replacing homegrown solutions outside of Epic that are less robust and secure; (3) staff find the data input ‘straightforward’, but not the reporting functions; and (4) implementation support feedback on clinic’s own tool use is helpful, but engagement is difficult due to clinics’ many competing priorities.

**Conclusions on Impact on Health Centers:** The EHR presents new opportunities for identifying and tracking insurance status within CHCs. EHR-based tracking tools could capture automated data and support health insurance outreach from within the CHC both during and between patient visits. Our early evaluation suggests the tools are perceived as helpful and adoption is increasing. However, many factors such as staff turnover or competing priorities are impacting tool uptake and adherence. Final analyses will inform tool effectiveness, further development and, if indicated, more widespread implementation of the tools.

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**Presenter(s):** Aleksandra Sumic

**CP65**

**Project ECHO Complex Care Management: Using Technology to Support Primary Care Nurses**

**Poster Type:** Innovation

**Primary Funding Source:** HRSA NEPQR 7/1/2015 to 6/30/2018

**Category:** Behavioral Health Services; Improving Care for Special Populations; Quality of Care and Quality Improvement; Technological Solutions and Tools to Improve Care and Population Health Management; Workforce

**Issue or Challenge:** Project ECHO Complex Care Management (CCM) addresses the challenges primary care nurses face while caring for medically complex patients and in their transition to the role of nurse care manager. Project ECHO CCM supports nurses as they engage in CCM by empowering their leadership and collaboration skills and equipping them with the necessary knowledge and skills to care for unique and ever-complex patient populations.

**Description of Innovation:** While there are several established Project ECHO programs specifically addressing the knowledge needs of primary care providers, Project ECHO CCM is one of the first specifically targeting primary care nurses. This successful platform has been adapted to suit the learning objectives of nurses by tailoring components, such as the didactic topics and the scope of faculty members. This innovative approach allows the didactic portions to be uniquely designed to build nurse leadership and to directly support nurses as they engage in CCM. In order to support the nurse role as part of a holistic care team, a faculty team of multidisciplinary specialists was developed. These faculty members advise the nurses in areas of their respective expertise including medical, nutrition, pharmacy, behavioral health, home-based care, and social services. This aids in supporting nurses to better participate on the interprofessional care team, as well as to successfully navigate their transition from staff nurse to gaining the competency of complex care management.

**Impact or Result:** Nurse Leadership: Through a series of focus groups, individual interviews and surveys related to CCM ECHO, we consistently evaluated the impact that this platform offers as a tool for the development in nurse leadership and role transition. We were able to better understand the main concerns primary care nurses need support with in managing complex patients, so as to better hone the intervention and didactic support. We will be reporting on implementation data, including number of sessions, topics/didactic support, along with percent of nurses that have participated, and number of unique patients presented.

**Replicating This Innovation:** Other organizations can begin by doing an internal assessment of existing resources that they may be able to leverage (e.g., potential ECHO faculty members, technical infrastructure, chief nursing officer or other clinical chief leading nursing). After an internal assessment, they can then begin to reach out to external partners for consultation on organizational collaboration and participation as faculty members. They should also assess their move toward value-based care and the resources they have in place to accomplish this. Primary care nurses are a key role in both the Patient-Centered Medical Home model as well as value-based care overall.

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Data-Driven, Team-Based Care Strategies to Improve Chronic Disease and Preventive Care Outcomes in FQHCs

Poster Type: Innovation

Primary Funding Source: Agency for Healthcare Research and Quality (AHRQ) and Centers for Disease Control and Prevention (CDC)

Category: Technological Solutions and Tools to Improve Care and Population Health Management

Issue or Challenge: CHCANYS, New York State’s Primary Care Association, aimed to enable FQHCs to successfully deliver high-quality, patient-centered, cost-effective primary care for medically underserved populations while positioning them for success in value-based healthcare and payment arrangements. In 2016, CHCANYS implemented and evaluated an innovative practice facilitation model of technical support to drive and sustain clinical and technical primary care transformation. CHCANYS developed the Center for Primary Care Informatics (CPCI), a data reporting and analytics solution that provides NY State’s FQHCs with reliable data and serves as the foundation for CHCANYS’ unique practice facilitation coaching model.

Description of Innovation: In 2016, CHCANYS implemented and evaluated an innovative practice facilitation model of technical support to drive and sustain clinical and technical primary care transformation. The model targets operational efficiency and systems-level change through implementation of HIT-enabled clinical care. CHCANYS developed a data reporting and analytics solution called the Center for Primary Care Informatics (CPCI). A modular curriculum was designed by CHCANYS, based on literature and industry experts, to ensure FQHCs received technical assistance that assisted them with adopting value-based care strategies. On-site coaching by certified practice facilitators builds trust in the data, ensuring routinized data hygiene, further emphasizing the value of EHR data. The in-person interaction between the practice facilitators and the health center staff creates a relationship and awareness that enables CHCANYS to tailor technical assistance to meet each health center’s capacity to adopt team-based care strategies and data optimization. The content follows a structure, but allows for flexibility based on each health center’s needs. As a result, FQHCs are adopting data-driven team-based care strategies that improve chronic disease and preventive care outcomes. Effective strategies will be discussed, such as methods of implementing team-based care models, workforce enhancement that shares patient care responsibilities, increased huddles for better communication and relationship building, and effective pre-visit planning to close clinical care gaps. The results from 12-months of practice facilitation on-site coaching will be shared.

Impact or Result: The impact of the innovation was an increase in health centers that are using the pre-visit planning tool that supports team-based care. Health centers are also experiencing a reduction of care gaps in their patient population, whether it be for chronic diseases or prevention, which increases quality of clinical care. Team-based care is also helping health centers improve their operations, including redesigning workflows to appropriately and safely redistribute patient care responsibilities. Health center staff are improving their working relationships, seeing each other as colleagues that “share the care.” Providers are able to reduce tasks that can be distributed with confidence to their colleagues.

Replicating This Innovation: Other organizations can get started in replicating this innovation by getting health centers to connect to a cloud-based data analytics platform that meets the specific needs of FQHCs. The data helps FQHCs to compare themselves against their peers, review their performance across measures, and increases access to patient-level data that is accurate and timely, allowing for actionable steps for an empowered care team to take to improve overall population health. Practice facilitators that are trained in core concepts of value-based payment are needed, but have soft skills needed for change management, are preferred. The facilitators help health centers to adopt HIT-enabled clinical care within the context of each health center’s unique needs. In addition, the practice transformation moves away from a measure-specific QI focus to one that is strategic in meeting multiple measures for a patient and for a population.

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Presenter(s): Sonia Panigrahy

Community Vital Signs: Using Neighborhood-Level Data for Research, Care Delivery, and Population Health Management

Poster Type: Innovation

Primary Funding Source: Patient-Centered Outcomes Research Institute (PCORI)

Category: Technological Solutions and Tools to Improve Care and Population Health Management

Issue or Challenge: We know that “place matters” when it comes to health, yet integrating geospatial information into primary care practice and research has only recently gained momentum. As we further develop an understanding of social determinants of health (SDH), and the similar effects that our “neighborhood” can have on our well-being, it’s become evident that integrating these factors into our overall understanding of population health is an innovative and critical step forward. Vulnerable populations may have less agency in their residential choices, and considering the context in which individuals live is key to understanding access to resources and limitations to receiving quality care.

Description of Innovation: OCHIN, Inc. is a non-profit healthcare innovation center providing health information technology solutions to a network of safety-net clinics across...
“Community Vital Signs” (CVS) is an initiative at OCHIN that further develops on the Institute of Medicine’s recent call to enhance the electronic health record (EHR), with patient-reported SDH, by integrating community-level variables into the EHR using an extensive database of geospatial information compiled and updated regularly through our project partners at the Robert Graham Center. The result is a comprehensive picture of the social and physical environment within every census tract, county, and ZIP Code Tabulation Area (ZCTA) across the U.S., drawing on publicly-available data related to topics including demographics, poverty, education, crime, and healthcare quality/access. The de-identified addresses of patients in OCHIN’s Research Data Warehouse are then linked to this geographic data, informing analyses and illustrating the relationships between neighborhood-level conditions and health outcomes.

Clinicians seeing patients can also access these data using Acuere, a web-based data aggregation and analytics tool developed by OCHIN to assist healthcare organizations in care delivery and population health management. Acuere allows users to access a comprehensive registry of clinical and financial data that can be used for targeted patient outreach and quality improvement. Using the web-based platform, providers are now also able to view data on the CVS of the patient’s neighborhood, allowing clinicians and care teams to gain an objective understanding of the daily environment for context-informed care.

Impact or Result: Upon embarking on the CVS initiative at OCHIN, we immediately created a team of analysts, project managers, and investigators who meet twice a month with our project partners to vet proposals, discuss feasibility of projects, and review analysis plans and results. The collaborative nature of this project means that the data are put to the best use possible, as ideas are exchanged within the group and disseminated beyond OCHIN to other healthcare research organizations. At the same time, OCHIN member clinics that use Acuere have seen improvements in quality measures and patient care due to the improved understanding of context, location, and risk.

Replicating This Innovation: Organizations and investigators interested in using the CVS data can work with OCHIN to develop a proposal targeted to specific funding agencies, and upon approval first through the OCHIN Research Leadership Team and later the funding institution, can draw on these data for analysis. Acuere is available to clinics for purchase as well, even to those outside of the OCHIN network; and extensive support provided from our team of software developers is also offered.

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Presenter(s): Sophia Giebultowicz

Conclusions on Impact on Health Centers: Many CHCs face challenges recruiting and retaining clinicians. This research project will provide insights into the recruitment of family medicine physicians. This project may provide insights into the retention of family medicine physicians.

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Presenter(s): Jose Mata

Ten-Year History of Postgraduate Nurse Practitioner Residency and Fellowship Training Programs: Challenges, Opportunities, and Outcomes

Poster Type: Innovation
Category: Workforce

Issue or Challenge: The intensity of clinical complexity that is the “norm” for the patient population in FQHCs, coupled with the intensity of socio-behavioral challenges, presents significant challenges to new nurse practitioners (NPs) seeking to join FQHCs and serve as primary care providers (PCPs). This
gap may deter NPs from choosing FQHCs, and FQHCs from hiring new NPs. Community Health Care, Inc.’s (CHC’s) study of the issue concluded that this gap is largely due to the systemic lack of post-graduate residency training for new NPs. It is the intensive, full-time immersion training experience within the service delivery organization that is the hallmark of residency training that will successfully address this gap.

**Description of Innovation:** The leadership of CHC shares a common belief that the near and long-term shortage of PCPs, coupled with the predicted aging of the current physician workforce and the increasing demands for primary care by newly insured patients under the Affordable Care Act, calls for new and innovative approaches. In addition, these leaders recognize that primary care NPs are ideal candidates to serve as PCPs in the complex setting of community health centers, given their professional orientation, interest, and training towards holistic care that integrates the personal, clinical, familial, social, and community aspects of preventive, routine, and chronic illness care into practice.

In 2007, CHC launched the nation’s first postgraduate nurse practitioner residency training program to support the transition from new NP to PCP. The goal is to provide new NPs with a depth, breadth, volume, and intensity of clinical training necessary to serve as primary care providers in the complex setting of the country’s FQHCs. Now in its tenth year, CHC has expanded its program capacity from four to ten residents per year, has graduated 56 NP residents, and annually receives more than 150 applications from across the country. CHC’s intent was to create a program that could and would be nationally replicated. To that end, it has developed significant infrastructure including curriculum, evaluation tools, preceptor trainings, didactic content, recruitment strategies, and marketing materials. Organizations from 45 states have sought CHC consultation for initiating a nurse practitioner residency training program.

**Impact or Result:** Our success is reflected in the numbers of new NP residency training programs that have been established and the increasing number of postgraduate NP residency programs in development. CHC led the development of the “National Nurse Practitioner Residency and Fellowship Training Consortium” (NNPRTFC), a new organization which grew out of collaborative efforts among the early NP residency programs across the country to advance the work of establishing and supporting these programs nationally. The Consortium explores sustainable funding strategies and develops standards that will lead to accreditation. As of January 2017, there are 38 primary care NP residency training programs across the country, of which, 24 are FQHCs. To date, nationally there have been 148 graduates of primary care NP residency programs, with 302 currently enrolled this year. CHC was awarded a National Cooperative Agreement (NCA) on clinical workforce development, focused on team-based care and training the next generation.

**Replicating This Innovation:** We are now in our 11th year and remain very committed to helping other organizations around the country develop similar programs. To that end, it has developed significant infrastructure including curriculum, evaluation tools, preceptor trainings, didactic content, recruitment strategies, and marketing materials. With CHC’s National Cooperative Agreement (NCA) we are supporting health centers by providing education, technical assistance, and training around “training the next generation.” Health centers can view recorded webinars and access tools and resources to help learn how to implement a postgraduate NP residency training program. Information is free and made available on our NCA website located at www.chc1.com/nca. Our NP residency team is also always available to help organizations who are interested in replicating this innovation.

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**Presenter(s):** Kerry Bamrick

**CP70**

**The Community Health Center Track: A Novel Third-Year Clerkship Track**

**Poster Type:** Innovation

**Category:** Workforce

**Issue or Challenge:** Workforce recruitment and development are well-established known challenges for community health centers (CHCs). It is well known that physicians end up practicing in settings and locations familiar to them from their training. We seek to develop and foster familiarity and comfort with the CHC environment, through exposure to medical students throughout the majority of their third-year clerkship experiences.

**Description of Innovation:** Workforce development, including training of the workforce of the future, is paramount to success for CHCs. We seek to increase interest in CHC medicine through increased exposure through a unique approach. Through a partnership with three FQHCs in Kansas City, Kansas City University College of Osteopathic Medicine (KCU-COM) is piloting an innovative approach to the third-year clerkship experience. Through the creation of a CHC track, interested students will complete required clinical clerkships, throughout the three FQHCs. Additionally, students will participate in three month-long selectives, including experiences in population health, quality improvement, addictions medicine, oral health, integrated behavioral healthcare and CHC administration. Additionally, didactic curricular content will be delivered on a monthly basis, covering the concepts included in health system science. CHC track students will also participate in longitudinal value-added experiential learning opportunities for the duration of the third year. Students will be assigned to one of the three FQHCs, where they will be incorporated as a functional team member in one of the patient care areas of the center, three half-days per month. In this setting, their duties may include functioning as a care coordinator/community health worker for a small number of patients on a panel,
participating as a member of the quality improvement team, or functioning in the rooming of patients in a school-based clinic.

**Impact or Result:** The practice of medicine and the health systems that support and compose it are together changing at an extremely rapid pace. Physicians are being called upon to not only change their own personal practice as a result, but also to lead their teams, their systems, and their profession through this change without any aspect of their training that prepares them for these changes. This is experienced acutely in CHCs. Concepts of value-based care, patient safety, quality improvement, team science, population health, social determinants of health, health informatics, and health care policy, now collectively included in the field of Health Systems Science, are all elements integral to these changes. Through early exposure to CHCs, we aim to affect a passion for these elements and CHCs in these young physicians, as they weave the fabric of their image of themselves as physicians.

**Replicating This Innovation:** In order for third-year core curriculum to be accomplished in an FQHC setting, available preceptors and clinic time for each of the required core clerkship rotations (pediatrics, women’s health, internal medicine, family medicine, and psychiatry) is necessary. Surgery is a required rotation also; since none of the three FQHCs have surgery available, the partner medical school is supplying the surgery clerkship site. A medical school, in relatively close proximity to the FQHC, with available medical students is also necessary. Finally, having CMs or other faculty available and willing to provide didactic curriculum on CHC specific topics is of benefit. Additionally, having various other clinical experiences from which a selective rotation can be designed is necessary as well. Finally, having staff either from the CHC or the partner medical school to help with the syllabi and curricula for the additional selectives and for the longitudinal clinical experiences is necessary.

**Author(s):**
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¹Health Partnership Clinic, ²Rodgers Health

**Presenter(s):** Anne VanGarsse

**CP71**

### Joint Venture Health: A Health Center-University Partnership to Support Workforce Development and Team-Based Care

**Poster Type:** Innovation  
**Category:** Workforce

**Issue or Challenge:** Like most community health centers, La Clinica is struggling with a chronic workforce shortage. At the same time, teaching institutions are beginning to recognize the importance of training students in out-patient primary care settings rather than in hospital settings to address the changes in healthcare delivery and future workforce demand. Two local universities approached La Clinica about establishing a program where students would be placed at the clinic to gain experience in team-based care in a primary care setting. La Clinica saw this as an opportunity to improve access as well as to build a primary care workforce pipeline.

**Description of Innovation:** The Joint Venture Health program is an innovative model for addressing access challenges, improving team-based care, addressing chronic disease health outcomes, and supporting primary care workforce development. The program is a collaboration between La Clinica, University of San Francisco, University of California at Berkeley, and University of California at San Francisco that trains and places nursing and medical students at La Clinica as health coaches. As a result, patients receive health coaching during their medical visit that they would not otherwise receive, while nursing and medical students obtain team-based training in primary care. The program recruits Spanish-speaking minority students to train a diverse pipeline of future professionals who have interest working in a low-income community health setting. Once trained, each student assumes the role of a health coach and supplements patient care in up to four distinct phases of a patient’s visit: before the visit, during the visit, at the end of the visit, and between visits. La Clinica has worked closely with the university partners to develop tools such as workflows, templates, and protocols in order to operationalize the care team approach and integrate the student health coach functions. With a vested interest in workforce development and build-out of the care team, La Clinica and its partners sought to evaluate how the model supports clinical quality, patient and provider satisfaction, clinic operations, and student development.

**Impact or Result:**
- **Patients embraced the program:** 92% of patients who received health coaching found student health coaches “very helpful”; 90% were “very motivated” to do something to improve their health.
- **Providers welcomed the help.** 80% of providers reported very positive experiences with precepting student health coaches.
- **Health outcomes improved.** Of patients with uncontrolled diabetes and/or hypertension who were served by health coaches in 2016, 47% saw a reduction in blood sugar level, and 53% saw an improvement in their blood pressure level.
- **Students valued the primary care experience.** One student said, “One of the most valuable skills that I have only acquired at La Clinica has been health coaching. At La Clinica we are fortunate to talk with our patients for as long as they need our help. We have built ... lasting relationships that not only improve our communications skills but also encourage us to continue our work.”

**Replicating This Innovation:** The Joint Venture Health program is highly replicable in other health centers. While there is infrastructure that must be built, along with relationships with university partners, health coaching is ultimately a well-established, easily-packaged model that can be quickly taught to health professional students. This program is appealing
to university partners who are looking for training sites for students and interested in exposing students to community health and primary care. Simultaneously, this program yields benefits for the health center via satisfied patients and providers, improved health outcomes, and relationships with students looking to join the ranks of community health centers.

Author(s):
Marianne Bruno, MPH, Senior Planner, La Clinica de La Raza, Inc.

Presenter(s): Marianne Bruno

CP72
The Development of a Provider Onboarding Program: Preparing New Graduate Advanced Practice Providers for Practice in FQHCs — WITHDRAWN

CP73
From Inception to Accreditation: Developing a Postdoctoral Psychology Residency in an Integrated Care FQHC Patient-Centered Medical Home

Poster Type: Innovation

Category: Behavioral Health Services; Workforce

Issue or Challenge: Having recognized the tremendous contribution made by psychologists to our integrated behavioral health program, we were dismayed at the short supply of such clinicians trained to this model. We hired recent graduates and trained them to our model, providing supervision as needed for them to qualify for the state licensing exams. Some left upon being licensed, after our investment of time and money into their training. Others stayed, but we noted a lower productivity during their training period. We developed a twelve-month postdoctoral residency training program that would help to address workforce development for us and for other integrated care settings, increase access for our patients by incorporating a large clinical component, and provide current staff with career development opportunities, all in a fiscally viable way. Planning steps included: looking at the ways in which our previous practice of providing on-the-job supervision and training for unlicensed psychologists had failed and/or was inefficient and addressing these issues in our training model; understanding the fiscal, staffing, structural, workflow, and time commitments needed to develop a viable model and making those commitments; educating ourselves in state and national licensing requirements for psychologists; determining which if any of the services these postdoctoral residents might provide under supervision would be billable services; joining the Association of Psychology Postdoctoral and Internship Centers (APPIC) and building the program according to their guidelines; becoming aware of American Psychological Association (APA) postdoctoral accreditation standards so that when we were eligible to do so, we could apply for accreditation; convening a leadership team, identifying and training supervisors, and training other staff to their role in having postdoctoral residents; examining all agency policies and procedures (including benefits and salary standards) to see which would and would not apply to one-year postdoctoral residents; building the workflow of how we would interview and select postdoctoral residents; and creating all the details of a program that would meet APA and APPIC standards while providing excellent training and patient care.

Impact or Result: More than 20 postdoc residents have been trained in the course of our program, most of who have remained in safety-net settings providing care to marginalized, complex need patients in integrated care settings. Psychology staff members who have been given the opportunity to supervise, teach didactic seminars, and/or participate in leadership roles in the residency have experienced increased job satisfaction and professional growth, helping with staff retention in the behavioral health department. Each postdoc targeted to see 900 or more client sessions per year, access to care has been increased for our patients. And the influx of new, enthusiastic staff each year who are brimming with the latest developments in the field has improved the skill level of all of the inter-professional staff working in the integrated pods in which the postdocs work.

Replicating This Innovation: Assuming that there is the will to a postdoc psychology residency in leadership and clinical psychology staff -- which is no small assumption since the development, implementation, and sustaining of such a program is labor intensive -- then the place to start is with assessing resources and determining if a postdoc residency is viable in the specific organization considering it. Initial considerations include: determining financial sustainability of the program; the existence of qualified supervisorial staff passionate about training the next generation; sufficient room for the residents to do their work; and sufficient clients to assure that they will have work to do which meets not only agency access needs, but also provides meaningful professional training to the postdoc. Becoming familiar with APPIC standards and utilizing them as a resource is a good first step too, as well as looking at APA accreditation standards for postdoctoral residencies.

Author(s):
R. Timothy Kearney, PhD, Chief Behavioral Health Officer, Community Health Center, Inc.

Presenter(s): R. Timothy Kearney
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## Upcoming NACHC Conferences and Trainings

**MARK YOUR CALENDARS!**

*(as of June 30, 2017 and subject to change)*

The National Association of Community Health Centers (NACHC) offers a wide variety of online and regional education trainings that encompass all facets of health center operations. Whether you need a refresher or are just starting out in a health center, NACHC offers trainings that will help you become more effective. Below is a partial list of upcoming trainings and conferences provided by NACHC.

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To register for these and future trainings, visit us at [http://nachc.org/trainings-and-conferences/](http://nachc.org/trainings-and-conferences/).

For additional information on NACHC Training, contact Sherry Giles at sgiles@nachc.com or Helene Slavin at hslavin@nachc.com.
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