



2021 Community Health Institute (CHI) & Expo

Poster Presentation Program

Poster Index

- CP1 - Preparing for Pandemics: Lesson Plan Design for Elementary-Aged Children
- CP2 - Prioritizing Preventative Health in Older Adults Residing in Long-Term Care Facilities Through Vaccination
- CP3 - Hepatitis C Treatment and Management Efficacy in a Primary Care Setting
- CP4 - Near North Quality Improvement Program: IPV Education, Awareness, and Resources
- CP5 - Teach-Back Method in Helping Patients Understand Their Diagnosis of Hypertension and/or Diabetes
- CP6 - Pour Some Sugar on Me: An Analysis of Diabetes Telehealth Follow-Ups
- CP7 - Examining Patient and Provider Perspectives of Telemedicine in a Community Health Clinic Setting
- CP8 - Virtual Health and Wellness Program for Elementary Students
- CP9 - Reviewing the Medical Utility of Incorporating Racial Identifiers in Common Diagnostic Tools
- CP10 - Team-Based Approach Including Behavioral Health, Nutritionist, and Primary-Care Physician to Improve Weight Management in Obese Patients at Community Health Centers
- CP11 - Mini Docs: A Novel Online Course Delivery to Empower Student Advocates for SARS-CoV-2 Safety on Oahu
- CP12 - Culture, COVID-19, and Community Impact
- CP13 - Why Patients Do Not Follow Through With Behavioral Health Referrals: Patient-Perceived Barriers in a Community Health Care Setting
- CP14 - Exploring Provider Stress and the Relationship to Recruitment and Retention in a Community Health Center System
- CP15 - Implementing a Blood Pressure Measurement Protocol to Improve the Diagnosis and Treatment of Hypertension
- CP16 - Addressing Food Insecurity by Increasing Awareness of Local Resources in Centreville, Illinois
- CP17 - Provider Preferences Regarding the Benefits and Challenges of Utilizing Telemedicine
- CP18 - Piloted Enhancements to a Screening, Brief Intervention, and Referral to Treatment Program in the FQHC Setting
- CP19 - Implementation of an Outpatient Alcohol Withdrawal Protocol at an Urban Community Health Center
- CP20 - 2019 Uniform Data System Report: An Analysis of Asian American-, Native Hawaiian-, and Pacific Islander-Serving Health Centers
- CP21 - New Immigrant Case Management: Responding to the Southwest Border Crisis in a New Jersey FQHC
- CP22 - Identifying COVID-19 Mortality and Social Deprivation Hot Spots and Exploring Opportunities for Health Center Response
- CP23 - Quality Improvement Network for Contraceptive Access (QINCA) 2.0: Integrating Reproductive Justice Through a Contraceptive Access Quality Improvement Program
- CP24 - The Influence of Meal Delivery on Engagement in a Digital Health Coaching Program
- CP25 - CareSouth Carolina MOBYs - Mobile Vehicles to Provide and Enhance Services for Our Patients

CP26 - A Model for Patient Outreach to Address Outstanding Preventive and Maintenance Health Care During the COVID-19 Pandemic

CP27 - The Role of Health Equity Navigators in Improving Access to COVID-19 Vaccines in Latinx Communities Through Community Health Centers

CP28 - Addressing Food Insecurity During the Pandemic

CP29 - Innovations to Sustain HIV and Hepatitis C Screening and Linkage to Care Efforts: Point-of-Care Testing Through Street Medicine Teams

CP30 - Addressing the Maternal Mortality Crisis in the Ambulatory Setting: A Quality Improvement Approach

CP31 - Improving Health Outcomes in Vulnerable Populations: The Medical-Legal-Partnership Colorado's (MLP-CO's) Experience

CP32 - The Role of Community Health Centers in Removing Barriers for Latinx Patients to Mobilize for Health Equity During the Pandemic

CP33 - COVID-19 Vaccine Confidence Among Federally Qualified Health Center (FQHC) Employees

CP34 - Adapting Dental Care Facilities to SARS-CoV-2: Reports from National Dental Practice-Based Research Network Practitioners

CP35 - Team-Based Home Blood Pressure Monitoring to Improve Hypertension Control Among Uninsured Patients

CP36 - ACCESS Westside Healthy Start: Impact of Integrated Support Systems for Maternal Child Health

CP37 - Diabetes Care Program: A Nurse-Led, Team-Based Approach to Chronic Disease Management

CP38 - Interprofessional Student Teams Add Value to Patient Care While Learning Team Skills

CP39 - Addressing Social Determinants of Health Through Mobile Medical Van in Miami-Dade, County

CP40 - Bite of HOPE

CP41 - Transforming Oral Health Care Through the Use of Teledentistry Before, During, and After COVID-19: FQHCs' Perspective

CP42 - Research Ready: Improving Clinic-Based Research by Engaging Clinic Support Staff

CP43 - Care Transformation: Care Team Roles and Realignment

CP44 - A Multi-Network, Nationwide Survey of EHR Satisfaction in CHC Users

CP1 - Preparing for Pandemics: Lesson Plan Design for Elementary-Aged Children

Poster Type: Research

Track/Topic: A. T. Still University;Patient and Community Engagement

Research Objectives: The purpose of this project was to implement education-based interventions via distanced learning about infectious diseases and pandemics to elementary-aged children. We aimed to evaluate the success of the online distribution and ultimately contribute to increased health knowledge.

Research Study Design/Methods: Our four-week program of weekly lessons was provided to 61 fifth-grade students. Each lesson included a 10–15-minute recorded instructional video and pre-quiz to be completed on Mondays, a 1-hour live, online, interactive session on Wednesdays, and a post-quiz completed on Fridays. Topics included: 1) basic understanding of microbes, 2) how germs spread, 3) preventing and treating disease, and 4) specifics of COVID-19. The students also completed surveys before and after the program to evaluate knowledge integration. Both surveys and all pre-post quizzes were sent and collected via the school's online portal.

Research Principal Findings and Quantitative/Qualitative Results: Overall, response rates varied, but an increase in correct responses on post-quizzes was found, demonstrating engagement and an increased understanding of topics. The response rates for the weekly pre vs post-quizzes are as follows: 56 vs 40 responses; 54 vs 49; 46 vs 39; 43 vs 39. Despite online curriculum delivery and distractions of learning at home, students seemed engaged during live sessions. Further analysis is being done to determine which topics the students learned most about and how confident they feel in their knowledge of infectious disease after the lessons.

Research Conclusions on Impact on Health Centers: These results suggest that interactive, evidence-based lesson plans help fifth grade students learn about infectious disease and related subjects. Although it was difficult to maintain the same response rate in the weekly quizzes and focused participation during the virtual lesson, engaging activities during the live sessions held students' attention and improved their understanding in these areas. This can provide children with greater confidence on how to navigate pandemics or similar scenarios in the future. This project design may also be adapted to other grade levels at schools across the country to promote awareness about pandemics or other global issues.

Authors:

Roxana Nouri-Nikbakht, MA, ATSU SOMA

Benjamin Finch, ATSU SOMA

Brittany Vaughn-Pierce, ATSU SOMA

Addison Hill, ATSU SOMA

Saleem Choudry, ATSU SOMA

Erin Herbert, ATSU SOMA

Sean Hollebeck, ATSU SOMA

Issa Ismail, ATSU SOMA

Daniella Rivera, ATSU SOMA

Zachery Sanders, ATSU SOMA

Steve Sainbayar, ATSU SOMA

Mark Sivakoff, MD, ATSU SOMA

Bradley Meek, MD, ATSU SOMA

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health, A T Still University School of Osteopathic Medicine

CP2 - Prioritizing Preventative Health in Older Adults Residing in Long-Term Care Facilities Through Vaccination

Poster Type: Research

Track/Topic: A. T. Still University; Quality of Care and Quality Improvement

Research Objectives: Long-term care facilities (LTCFs) house adults who require acute rehabilitation or long-term high-level care. Influenza and pneumonia cause 90% of deaths in adults 65+; only 42-66% of Pennsylvania LTCF residents receive these vaccinations. Given the COVID-19 pandemic, we aimed to identify perceived barriers to vaccination in LTCFs across Pennsylvania.

Research Study Design/Methods: LTCFs located in Pennsylvania, identified by zip-code, were contacted via publicly available contact information and administrators were asked to participate in an anonymous phone survey designed to gather information regarding vaccination practices. Our survey contained questions and discussion prompts designed to assess the following: how vaccines are recorded, what information is recorded, how charts are checked for vaccination gaps, the vaccination process, and perceived barriers to vaccination.

Research Principal Findings and Quantitative/Qualitative Results: Of 406 eligible LTCFs, 109 were contacted and 22 agreed to participate (20.2%). Thirteen centers reported use of electronic records; 7 use both paper and electronic records. Vaccine records reportedly included patient identifying information (95.2%), injection site (76.1%), injection information (38.1%), and vaccination history (90.5%). Methods for vaccine tracking included chart reviews (28.6%), electronic alerts (42.9%), scheduled audits (38.1%), and vaccination at admission (19%). The most common vaccination process involved a physician ordering and administered by a nurse (57.1%). The main barriers perceived by more than half of participants included lack of patient education and issues with vaccine acquisition.

Research Conclusions on Impact on Health Centers: Although vaccination is vital to preventative health, 52.4% of LTCFs perceived barriers in vaccinating their residents. We determined a baseline understanding of how LTCFs track vaccination status and perceived barriers they face in getting residents vaccinated. Individual LTCFs can examine their own system to understand gaps they may face in vaccinations. Given the importance of vaccination in bringing an end to the COVID-19 pandemic, recognizing potential impediments to achieving higher vaccination rates in such a vulnerable population is essential. Future research projects could look at steps that can be taken to overcome these barriers and ultimately increase vaccination rates.

Authors:

Aishwarya Majumdar, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Catherine Lau, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Tanisha Mitra, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Alonso Abugattas, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Margaret McGrath, OMS-II, A. T. Still University School of Osteopathic Medicine in Arizona

Christopher Vaccaro, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Dat Le, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Haneet Chadha, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Fatima Maqsood, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Sandra Rabat, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Alexander Silva, OMS-II, A. T. Still University, School of Osteopathic Medicine in Arizona

Erin McFadden, Internal Medicine Faculty Physician, Regional Director Medical Education, The Wright Center for Community Health

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health,
A T Still University School of Osteopathic Medicine

CP3 - Hepatitis C Treatment and Management Efficacy in a Primary Care Setting

Poster Type: Innovation

Category: A. T. Still University; Quality of Care and Quality Improvement

Issue or Challenge: Hepatitis C (HCV) is a highly prevalent infectious disease in Arizona. Despite its prevalence, many primary care providers feel unequipped to screen, diagnose, and treat HCV. This is largely due to the complexity and novel characteristics of HCV treatment along with persistent reliance on specialists to manage this disease. To address the growing burden in northern Arizona, this project aims to improve management of HCV by North Country HealthCare (NCHC) primary care providers (PCP's) through an educational session on the screening, diagnosis, and treatment of HCV.

Description of Innovation: Once recruited, participants followed the steps for completion that were emailed to them and provided on a recruitment poster. Between March 1-15, 2021, participants completed an electronic pre-survey to assess baseline comfort in screening, diagnosing, and treating HCV. Participants then watched an hour-long pre-recorded educational video presented by a NCHC family physician and resident HCV expert. The video provided guidance on managing HCV positive patients in the primary care office. The presenter expanded on updated USPSTF HCV screening recommendations, 2030 World Health Organization HCV elimination goals, simplified pharmacotherapy for eligible patients, advanced pharmacotherapy for complex patients (non-genotype specific), treatment cessation, treatment restrictions, and monitoring for patient follow-up. Participants completed post-surveys identical to the pre-survey both immediately and two weeks (on or before March 29, 2021) after watching the video to assess change in knowledge and comfortability. The secondary post-survey, administered two weeks after the educational session was intended to assess sustained improvement in HCV management. The survey results were compared using Stata.

Impact or Result: Out of 81 eligible primary care providers at NCHC, ten agreed to complete the educational session (12.3%). Their knowledge of HCV treatment increased by 9.9% immediately after the education (95% CI: -11.6, 31.4; p-value: 0.3468). Providers without previous HCV training had higher average pre-education assessment scores (83.5%) and greater improvement in post-education assessment scores (16.5%) compared to providers with previous training (72.3%; 5.5%). Prevalence of comfortability in screening, diagnosing, and treating HCV increased from 3 to 8 providers, 2 to 7 providers, and 2 to 8 providers respectively. At the two-week follow up, 6 providers responded and scored 100% on the knowledge assessment. All 6 providers selected agree or strongly agree to questions assessing comfort level with screening and diagnosing, and 5 providers chose agree to comfort with treating.

Replicating this Innovation: Organizations may replicate this project by utilizing a provider or group of providers that possess knowledge of HCV management. Next, either a pre-recorded or live educational session could be developed to address HCV management. To incentivize providers to participate, CME credit may be offered, if applicable. Although a limitation within this study, improved participation could be assured by increasing publication of the session amongst providers at the organization. Having resident experts available may also reduce potential barriers as they offer expertise to providers who are new to HCV management. Developing clinic-specific treatment tools and guidelines may also increase sustained knowledge.

Author(s):

Riva Macbeth, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Annalise Wille, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Jasmine Dugal, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Justin Kleinman, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Justin Morin, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Joshua Sturgell, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Luke Allen, MPH, CPH, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Shahim Elja, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Steven Jang, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Rita Bybee, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Shipra Bansal, MD, A.T. Still University School of Medicine Arizona

Brandon Abbott, DO, North Country HealthCare

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health, A T Still University School of Osteopathic Medicine

CP4 - Near North Quality Improvement Program: IPV Education, Awareness, and Resources

Poster Type: Innovation

Category: A. T. Still University; Quality of Care and Quality Improvement

Issue or Challenge: Intimate partner violence is a widely prevalent issue and most significantly impacts women, especially in the city of Chicago. The health consequences of IPV are significant including chronic pain disorders, IBS, sexually transmitted infections, infertility, depression and anxiety, maternal mortality, suicide, and homicide. Despite this, a previous project at Near North Health found that there is minimal screening by their providers. The goal of this project is to increase the identification of patients experiencing IPV.

Description of Innovation: Colloquially, innovation implies newness—new technology, methods, or ideas. However, innovation in qualitative research can mean improvement of methods that have already been established. The goal of this experiment was the latter. Through the survey conducted by 10 A.T Still University students, Class of 2022, it was established that physicians at Near North Community Health Center (NNCHC) were not comfortable screening patients for IPV. We decided to address this issue through IPV education seminars to increase physicians' knowledge on IPV. This seminar explained risk factors, and equipped providers with tools and resources that they can provide to their IPV positive patients. Other resources are business cards that providers can give to patients containing IPV related information and resources. In addition, posters with information regarding IPV and a QR code for an IPV safety planning app will be posted in bathroom stalls of the clinic in an effort to increase patients' comfortability in starting a conversation about IPV with their physicians. Through provider education, business cards, and posters, we aim to increase provider's comfortability to screen patients for IPV at Near North Health Center.

Impact or Result: Our team created a training presentation to succinctly educate our providers on the current issues regarding IPV and how to best screen for IPV among their patients. We had six women's health providers attend the training and complete pre- and post-training surveys. Our providers were asked to rate their knowledge of resources available for patients experiencing IPV prior to training (1-5) and subsequently asked the same question after training. We observed a positive trend regarding knowledge of resources, from an average of 2.67 prior to training to 4 after training. We also obtained important information regarding barriers to IPV screening. Multiple providers indicated that lack of time to screen patients as well as lack of time to discuss a positive IPV screen were seen as barriers to screen.

Replicating this Innovation: The importance of replicating this quality improvement project in other organizations cannot be understated. The educational presentation was created to educate women's health providers at Near North Health Services on multiple aspects of IPV and improve provider comfortability in screening for IPV. Importantly, the educational presentation produced was succinct and straight forward. Moreover, while this program specifically focused on educating women's health providers at one community health clinic, the content of the presentation - and the online format - lends itself to being easily accessible to multiple audiences.

Author(s):

Michael Dinh, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Grace Chen, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Ryan Abbott, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Trina Bhattachari, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Tanya Omar, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Donald Saylor, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Caroline DiNicola, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Clara Choi, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Daniel Muller, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

Grace Narlock, OMS-II, A.T Still University School of Osteopathic Medicine in Arizona

CP5 - Teach-Back Method in Helping Patients Understand Their Diagnosis of Hypertension and/or Diabetes

Poster Type: Research

Track/Topic: A. T. Still University;Patient and Community Engagement;Quality of Care and Quality Improvement

Research Objectives: Our project aims at increasing health literacy in adult patients of Near North Health Services Corporation of Illinois with hypertension and/or diabetes using the Teach-Back Method. We also look at patient belief in knowledge about disease pre and post intervention, and evaluate how patients feel about the intervention.

Research Study Design/Methods: Investigators meet with patients before discharge following an outpatient appointment. A pre-educational survey is administered to assess patient knowledge of Hypertension or Diabetes. Education is provided on their applicable diagnosis through information sheets as part of the Teach-Back intervention. Patients are given an opportunity to discuss information learned from the intervention, following which, patients complete a post-educational survey that assesses their knowledge of disease following the intervention. The survey also assesses how patients feel about the intervention in helping them understand their diagnosis. Results from pre and post surveys are compared descriptively.

Research Principal Findings and Quantitative/Qualitative Results: There were 30 patients who participated in the intervention and completed both pre and post surveys. Prior to intervention, 53% felt that their understanding of the diagnosis was somewhat clear. However, post-intervention, 63% patients felt that their understanding of the disease was very clear. All respondents reported learning something from education provided. Additionally, most patients (83%) reported that the intervention helped them grasp their medical condition much better than previously felt. Most patients felt that providers need to use the Teach-back method to explain diagnosis.

Research Conclusions on Impact on Health Centers: The intervention empowers patients by increasing their knowledge about their condition and how to manage their disease. We hope that this intervention increases patient participation in their care, therefore leading to improved patient outcomes. As suggested by patients, our intervention can be incorporated in physician-patient interaction at discharge with new diagnosis for metabolic conditions at all health centers. Additionally, this intervention can be adapted to the management of various different chronic conditions which benefits from increased patient knowledge about diseases and engagement in care.

Authors:

Aveena Pelia, OMS-III, A.T. Still School of Osteopathic Medicine in Arizona

Trivianne Franklin, OMS-III, A.T. Still University School of Osteopathic Medicine in Arizona

CP6 - Pour Some Sugar on Me: An Analysis of Diabetes Telehealth Follow-Ups

Poster Type: Research

Track/Topic: A. T. Still University;Quality of Care and Quality Improvement;Technological Solutions and Tools to Improve Care and Population Health Management

Research Objectives: Diabetes rates in Tucson, AZ are high. During the COVID-19 pandemic, sociodemographic factors contributing to diabetes were further compounded by unemployment, virtual education, and fear of contracting COVID. These elements increased the use of telemedicine. This project assesses efficacy of telemedicine for diabetes follow-up and patient preferences for continued use.

Research Study Design/Methods: El Rio Health Center in Tucson, Az reports over 10,500 diabetic patients. Patients 18-75 years old with a documented HbA1c = 7.0 between July and December of 2020 were recruited. El Rio provided a list of 3,024 patients who met these criteria, and 100 patients were randomly selected to be contacted. Patients were called via Doximity dialer and asked to answer questions based on utilization of telehealth or in-person visits. Survey questions were verbally conveyed in English or Spanish related to diabetes control, satisfaction with healthcare visits, and likelihood of choosing telemedicine in the future.

Research Principal Findings and Quantitative/Qualitative Results: 38 of 100 patients agreed to complete the survey. Of those sampled, 24 used telemedicine between July and December of 2020, and the majority were satisfied versus dissatisfied with the care received (Question 6, P=.01). Responses for quality of diabetes management tended to be improved versus worse (P=.001). There is not enough evidence from responses to show if in-person visits provided greater quality of care in contrast to telemedicine visits (Questions 7 & 10, P=.16). Overall, responses showed patients are more likely to utilize telemedicine visits in the future (P=.006).

Research Conclusions on Impact on Health Centers: Responses demonstrated that patients who utilized telemedicine visits between July 2020 and December 2020 felt there was equal quality of care provided compared to in-person visits. A majority of patients expressed interest in continuing to utilize telemedicine in the future for diabetes follow-up visits. These results show the practicality and utilization of telemedicine for the future management of patients with diabetes. This quality improvement project can be modeled by other clinics interested in assessing satisfaction with their telemedicine services.

Authors:

Nihaal Shah, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Courtney Alakan, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Brandon Poppe, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Jennifer Concepcion, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Charissa Gregory, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Ellis Kaufmann, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Michaela LaCorte, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Marissa Meyer, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Ashley Oalickal, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Trevor Swanson, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

Christopher Dixon, DO, Regional Director, Medical Education, A T Still University School of Osteopathic Medicine

Ray Wagner, MD, MS, FAAP, Regional Director, Medical Education, A T Still University School of Osteopathic Medicine

Ruth Garcia, Regional Director, Medical Education, A.T. Still University - School of Osteopathic Medicine in Arizona

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health,
A T Still University School of Osteopathic Medicine

CP7 - Examining Patient and Provider Perspectives of Telemedicine in a Community Health Clinic Setting

Poster Type: Research

Track/Topic: A. T. Still University;Quality of Care and Quality Improvement

Research Objectives: Telemedicine usage has grown exponentially but little literature examines its use in community health clinics. This project examined patient and provider perceptions and experiences of telemedicine in two CHC settings with diverse patient populations in order to help participating sites improve and maximize their delivery of telemedicine.

Research Study Design/Methods: We are surveying patients at two CHCs in Brooklyn, including those who have and those who have not used telemedicine, using anonymous paper surveys which are collected in waiting rooms. Patient surveys assess usefulness, interface quality, ease of use, communication, access to telemedicine necessities, safety/security, and satisfaction. Surveys of those who have not used telemedicine also assess patient concerns regarding telemedicine. Demographic characteristics collected include race/ethnicity, primary language, gender, and age. Providers at the CHCs are surveyed via anonymous online survey distributed by email. Surveys assess usability, quality of communication, usefulness, perception of patient telemedicine experience, and satisfaction.

Research Principal Findings and Quantitative/Qualitative Results: Data collection is ongoing. 246 patients have been surveyed with a response rate of 68.7%. We will analyze results using statistical analysis and stratify by race/ethnicity, primary language, age, and gender to look for differences in findings. We will compare responses from patients who have used telemedicine compared to patients who have not to identify factors that differ between the groups, including differences in group characteristics and in perceptions of telemedicine. Provider survey results will be analyzed for trends and themes in the survey topics covered. Data collection will stop May 31 and results will be ready June 14.

Research Conclusions on Impact on Health Centers: We hope our findings will provide greater insight into the usage and acceptability of telemedicine amongst vulnerable patients. Findings will be presented to participating sites' administrations and may inform them of ways to improve their telemedicine service for both providers and patients as well as how to cater telemedicine to their specific patient populations and address barriers. Although our findings are not generalizable, other CHCs can use a similar methodology and survey system to assess their usage of telemedicine, and can learn from our findings as they consider ways to improve their own telemedicine programs.

Authors:

Emilie Doan Van, MPH, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Anirudh Singhal, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Nilioufar Akhavan Tabib, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Ryan Andrade, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Mark Calandra, BSN, RN, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Myrna Hanna, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Tahmin Hassan, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Peter Oro, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Richelle Reznik, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Dhipthika Srinivasan, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Laura Grady, DO, Regional Director of Medical Education, A T Still University School of Osteopathic Medicine

Norma Villanueva, MD, MPH, Regional Director of Medical Education, A T Still University School of Osteopathic Medicine

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health,
A T Still University School of Osteopathic Medicine

CP8 - Virtual Health and Wellness Program for Elementary Students

Poster Type: Innovation

Primary Funding Source: A.T. Still University

Category: A. T. Still University; Patient and Community Engagement; Social Determinants of Health

Issue or Challenge: The COVID-19 pandemic presented many challenges, and one faced by adolescents was distance learning. A needs assessment, conducted with Family HealthCare Network (FHCN) in Tulare County, identified the need for supportive services for adolescents. An open forum held with the FQHC in September 2020 demonstrated the mental health problems experienced by students during distance learning, such as increased anxiety and feelings of isolation. This project's goal was to evaluate the success of a virtual wellness program designed to support the mental welfare of children as they navigate online learning as a result of the COVID-19 pandemic.

Description of Innovation: A needs assessment was completed in the community through FHCN, a Federally Funded Health Center, and it was identified that adolescent mental health, in the face of online learning due to the COVID-19 pandemic, was a challenge that had yet to be addressed. We formed a partnership with a local elementary school and gained their support for this project. We chose five health and wellness topics that would encourage children to be active and to engage in wellness activities outside of their classroom work: aerobic exercise, guided meditation, yoga, origami, and nutrition. Utilizing professional filming and editing, we filmed 5 videos on these topics. The videos were designed to be engaging and applicable but also educational for children. Over the course of 5 weeks, we released 5 wellness-based videos through the school that were distributed to students, with attached surveys for feedback on these videos. Students were encouraged to participate with a raffle where students could win prizes that were related to the wellness videos and survey completion. Videos will also be made permanently available to students through the school's own Google Classroom.

Impact or Result: Data collection is ongoing, but videos released thus far were met with positive reception. From 2/25/21-3/25/21, 4 videos were released, which have collectively received 136 views. These videos require direct links to view, so the 136 views were solely completed by students at the participating school. Following the project's completion, the school will make all 5 videos available to students through Google Classroom. Feedback received via the 31 surveys received thus far has been positive. Several students praised how the videos taught them beneficial calming techniques, and others liked the high engagement level. Complaints addressed video length, demonstration clarity, and small editing recommendations. One video has yet to be released. All video surveys will be open until 4/15/21. Overall, this project has received positive feedback from students, and will hopefully improve students' wellbeing and enhance the health of the community.

Replicating this Innovation: This innovation can be replicated in other organizations and would be beneficial due to its emphasis on adolescent health which will hopefully influence the overall health of the community. Strategic partnerships with organizations that serve the community en masse, like FHCN in this project, and nearby schools may be beneficial to extending the program's reach. Modifications can be made to the type of wellness content depending on the specific community, organizational, or adolescent needs.

Author(s):

Aaron Lai, A.T. Still University, School of Osteopathic Medicine at Arizona

Sayeh Akhavan, A.T. Still University, School of Osteopathic Medicine at Arizona

CP9 - Reviewing the Medical Utility of Incorporating Racial Identifiers in Common Diagnostic Tools

Poster Type: Research

Track/Topic: A. T. Still University;Quality of Care and Quality Improvement;Social Determinants of Health

Research Objectives: To identify the usefulness of racial identifiers in 6 commonly used healthcare diagnostic tests. Through literature review, evidence against the use of racial identifiers in some diagnostic tests were found. Our aim is to increase awareness of this evidence and how racial identifiers have been used in these diagnostic tests.

Research Study Design/Methods: Our project started with a literature review of 6 diagnostic tools that commonly reference racial identifiers. We gained a better understanding of how race plays a part in these tests and corresponding conditions. Based on what was learned, we created an informational video of our findings and presented it to providers at HealthPoint, who then completed a qualitative survey that included questions assessing their opinions on how the racial identifiers were used and their interest in learning more about racism in healthcare. As an incentive for participation, a free catered lunch was offered to the site with the most participants.

Research Principal Findings and Quantitative/Qualitative Results: After investigation, VBAC, STONE, Breast Cancer Risk Assessment and DEXA lacked sufficient evidence to support continued use of racial identifiers. Bilitool and Hemoglobinopathy screening has evidence supporting continued use of self-identified race until a better method is clinically available. Overall, the providers' responses (n=60) supported that they understood and agreed with the evidence presented. Over 60% of providers agreed the use of race lacked support in VBAC (83.33%, n=50), STONE (78.33%, n=47), Breast Cancer Risk Assessment (61.67%, n=37) and DEXA screening (66.77%, n=40). Maintaining self-identified race in BiliTool and Hemoglobinopathy was more controversial with 48.33% (n=29) supporting continued inclusion.

Research Conclusions on Impact on Health Centers: Overall, our project showed that the validity of including racial identifiers in patient care is varied, and the literature is limited. We also need to consider if race is being included as a proxy for social determinants of health, such as access to care, income and social status. Using it this way, it disregards the diversity of social determinants of health within each racial category. Further research should be conducted before using racial identifiers, as unnecessary usage, except in the case of a biologically significant association, has the potential to lead to unnecessary testing or worsened health outcomes.

Authors:

Naomi Mathews, OMS-II, A.T. Still University School of Osteopathic Medicine

CP10 - Team-Based Approach Including Behavioral Health, Nutritionist, and Primary-Care Physician to Improve Weight Management in Obese Patients at Community Health Centers

Poster Type: Research

Track/Topic: A. T. Still University;Behavioral Health Services;Quality of Care and Quality Improvement;Social Determinants of Health

Research Objectives: Determine whether a team-based approach for weight management during the same office visit would improve weight management for obese patients at CHC. To effectively educate patients to identify barriers regarding their weight management and learn alternatives in their diet. To increase patient's satisfaction with weight management at CHC.

Research Study Design/Methods: Patients were recruited from a single healthcare provider's population base before their visit. Inclusion criteria included patients over the age of 18 and a BMI over 30. Patients first met with their PCP for standard of care, followed by 10-minute visits with behavioral health and nutritionist separately. Afterwards, a post-survey questionnaire was filled. The survey consisted of 4 questions with a score ranging from 1-5, and it also included a comments section for qualitative data. Patients were followed up in one year to compare changes in BMI since the initial visit and with a phone interview.

Research Principal Findings and Quantitative/Qualitative Results: In total, 20 patients were enrolled in the study (11 males and 9 females). Mean age in years(SD) and BMI(SD) were 49.4(11.52) and 34.17(2.8), respectively. The mean score(SD) for the first post-survey question regarding overall satisfaction was 4.75(0.44). The mean score(SD) for the second post-survey question regarding behavioral health specialist was 4.70(0.47). The mean score(SD) for the third post-survey question regarding the nutritionist representative was 4.70(0.47). The mean score for the fourth post-survey question regarding motivation for weight loss was 4.75(0.44). There was no significant difference in change in BMI between initial and post one-year visit, 33.59 vs 33.79 ($p=0.41$).

Research Conclusions on Impact on Health Centers: Patients rated high scores in the post-survey questionnaire, with mean score averages all being higher than 4.7/5. Overall, most patients at the initial visit said that this team-based approach provided additional and helpful information about weight management when compared to speaking with just their PCP. COVID-19 played a significant factor in the one-year follow-ups on participants in terms of their BMI. This team-based approach strategy for weight management can be effective for patients at CHC. We recommend expanding the current study to include larger sample size, expanded to multiple CHC sites, and measuring long-term assessment of team-based approach post-COVID-pandemic.

Authors:

Nobel Nguyen, OMS, A.T. Still University School of Osteopathic Medicine

CP11 - Mini Docs: A Novel Online Course Delivery to Empower Student Advocates for SARS-CoV-2 Safety on Oahu

Poster Type: Research

Track/Topic: A. T. Still University

Research Objectives: The Leeward coast population recorded a higher SARS-Cov-2 positivity rate compared to other Oahu regions. Health literacy education has been shown to prevent community-acquired infections. This program used short videos and Zoom to increase understanding of SARS-Cov-2 among middle school students and aid in disease prevention.

Research Study Design/Methods: 200 6th and 7th grade students were emailed the SARS-Cov-2 video project by their school and encouraged to participate voluntarily. They watched a 5-minute video regarding SARS-Cov-2, disease prevention guidelines, and healthy coping practices. Students completed identical, anonymous surveys before and after the video, to assess baseline knowledge and improved understanding on SARS-Cov-2 along with preventative practice measures. 100 students participated in a Zoom discussion session in break out rooms of 10-20 students after completing the surveys. Two weeks later, students completed an anonymous qualitative short answer reflection survey to assess if they continued these practices after the activities.

Research Principal Findings and Quantitative/Qualitative Results: Participants responded positively to small group discussions and taught coping strategies they learned. 58.5% responded to the pre-survey, 34% to the post survey, and 7% to the reflection survey. Before watching the videos, 68.4% of respondents rated their understanding of SARS-Cov-2 as high, 66.7% believed SARS-Cov-2 vaccines would protect them and their families, and 76.9% social distanced frequently. After watching the videos, 95.5% of respondents rated their understanding as high, 84.1% of students believed that SARS-Cov-2 vaccines would be protective, and 91.3% of students expressed intentions to practice social distancing more frequently.

Research Conclusions on Impact on Health Centers: This program, part of an on-going partnership between WCCHC and local schools, provided a unique perspective with the change to online learning. It was successful in increasing middle school students' understanding of SARS-Cov-2, how to protect themselves, their families, and community. Students reported positive behavioral and attitude changes, shared healthy coping strategies, and utilized what they had learned into their daily lives. Based on the positive results of this program, implementing a similar program at schools can assess generalizability across various underserved areas of Hawai'i. It is worth considering online learning as an additional effective teaching modality during pandemic restrictions.

Authors:

William Phillips, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health, A T Still University School of Osteopathic Medicine

Christina Adams, MD, A.T. Still University -School of Osteopathic Medicine Arizona

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Maria Salas Balajadia, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Charlene Mae L. Rocimo, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Therese Nicole A. Diñoso, OMS-III, , AT Still University School of Osteopathic Medicine in Arizona

Austin J. Wang, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Patrick Rim, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Kim Lim, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Jennifer Nordbye, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

Eun Ah Cho, OMS-III, AT Still University School of Osteopathic Medicine in Arizona

CP12 - Culture, COVID-19, and Community Impact

Poster Type: Research

Track/Topic: A. T. Still University;Quality of Care and Quality Improvement

Research Objectives: The purpose of this quality improvement project was to assess the attitudes and practices of adult patients, serviced by the North Central Texas Community Health Center in Wichita Falls Texas, in regard to COVID-19 prevention practices. This information may help determine gaps in participant knowledge and identify areas for intervention.

Research Study Design/Methods: An electronic survey was used to assess participants' knowledge of COVID-19 preventative practices. The survey consisted of 8 questions and utilized the Likert Scale to determine how often individuals practice social distancing, hand hygiene, and mask-wearing. The patient portal system randomly generated a list of patients that had previously consented to receive emails. These patients were automatically sent an email with an explanation and a link to an external survey tool, which was designed to be confidential and voluntary. The survey was available for approximately 2 weeks. A follow-up reminder email was sent one week later.

Research Principal Findings and Quantitative/Qualitative Results: The project is ongoing and data collection will be completed on April 28th. Results will be used to convey the prevailing attitudes and beliefs in the patient population of North Central Texas Community Healthcare Center based on a significant sample size. After online distribution to the target population for a period of 10 business days, we anticipate receiving 150 responses. We will perform quality control by ensuring that all questionnaires are completely filled out and de-identified. Identifying these gaps in either knowledge or belief will inform future interventions.

Research Conclusions on Impact on Health Centers: The results of this project will be used to demonstrate the level of understanding and level of adherence to personal hygiene and social-distancing protocols. We would theorize a number of reasons exist for any deficiencies, including a lack of awareness on appropriate pandemic etiquette, crowded/poor living conditions, and or inequitable access to resources such as protective equipment. These results may be used by care providers at NCTCHC to determine the types of education they may need to provide for their patients regarding COVID-19 prevention practices.

Authors:

Ezra Yu, OMS, A.T. Still University School of Osteopathic Medicine in Arizona

Brinton Wise, OMS, A.T. Still University School of Osteopathic Medicine in Arizona

Jacob Kaiser, DO, RDME, North Central Texas Community Health Center

Vicki Johnson, BS MT(ASCP), CHC, CHPC, Director of Compliance, North Central Texas Community Health Center

Kate Whelihan, MPH, CPH, COPC and Public Health Research Specialist, Department of Public Health, A T Still University School of Osteopathic Medicine

Joy H. Lewis, DO, PhD, FACP, Professor, Medicine and Public Health Chair, SOMA Dept. of Public Health, A T Still University School of Osteopathic Medicine

CP13 - Why Patients Do Not Follow Through With Behavioral Health Referrals: Patient-Perceived Barriers in a Community Health Care Setting

Poster Type: Research

Track/Topic: A. T. Still University;Behavioral Health Services;Quality of Care and Quality Improvement;Social Determinants of Health

Research Objectives: The purpose of this project was to determine the obstacles which prevented patients from scheduling or attending behavioral health sessions after a referral was made. Identification of perceived barriers may allow the community health center to address gaps within the continuum of care for patients in need of such services.

Research Study Design/Methods: Inclusion criteria included a behavioral health referral made between the dates of March 1, 2020 and September 31, 2020. This project focused on patients and families who failed to schedule or attend appointments after receiving the referral. A list of patients was assembled from five Family Health Centers (FHCs) within the NYU Langone system. Patients were contacted via telephone. After verbal consent was received, participants were asked about barriers they encountered which kept them from scheduling or attending sessions. Qualitative data were collected as anecdotes and the patient-perceived barriers were sorted into general categories, such as transportation, finances, etc.

Research Principal Findings and Quantitative/Qualitative Results: 827 patients met the inclusion criteria. Of 116 contact attempts made, 68 patients were reached and 57 consented to participate (response rate of 83.8%). Analysis of completed interviews reveals a range of reasons why appointments were not scheduled or kept, including, but not limited to: provider failure to contact patients to schedule sessions; lack of communication regarding the referral itself; personal belief that they did not require behavioral health services; concerns about in-person visits during a pandemic; scheduling conflicts; non-coverage by insurance; forgetfulness; lengthy gap between referral and available appointments; dissatisfaction from prior encounters; and choosing to use outside providers.

Research Conclusions on Impact on Health Centers: While there was no singular reason behind the absenteeism, certain themes became apparent in the data. Chief among them was a breakdown in communication between providers and patients. Many patients were not aware that they had been given a behavioral health referral in the first place and there seems to be a perceived lack of follow-up done by the provider regarding appointment scheduling. In addition, other factors such as financial worries, misconceptions about behavioral health, and systemic disruptions due to the COVID-19 pandemic also played a role. The findings will be provided to the Quality Improvement team at the FHCs.

Authors:

Edmund To, OMS-II, A.T. Still University - School of Osteopathic Medicine in Arizona

CP14 - Exploring Provider Stress and the Relationship to Recruitment and Retention in a Community Health Center System

Poster Type: Research

Track/Topic: A. T. Still University;Workforce

Research Objectives: The purpose of this study is to understand factors that affect primary care working conditions in community health centers and safety-net clinics and determine if there is a relationship between provider stress and recruitment and retention within the North Country HealthCare (NCHC) system.

Research Study Design/Methods: The NCHC administration asked its clinical providers to complete the Primary Care Provider Stress Checklist (PCP-SC) to assess stress in healthcare settings as it relates to the domains of patient interaction, practice management, administrative issues, education/learning, and relationships with colleagues, and work/life balance. NCHC also monitors clinical provider turnover as a part of continuous quality improvement within the organization. Using the results of the PCP-SC, organizational leadership targeted domains contributing to the stress of clinical providers for intervention and looked for interval changes in clinical provider turnover.

Research Principal Findings and Quantitative/Qualitative Results: PCP-SC was completed by 48 clinical providers in 2018 and 72 clinical providers in 2019 working at NCHC. Data analysis shows that interactions with patients, practice management, and administrative issues are the domains that contribute most to the stress in the providers of NCHC clinics. We were able to identify the specific interactions within each domain that contributed most to clinician stress. A review of the turnover rate within the NCHC health system showed a significant decrease from 2018 (27.8) to 2020 (12).

Research Conclusions on Impact on Health Centers: Recruiting and retaining a strong clinical workforce has become a pressing concern among the nation's community health centers. An increased rate of turnover of healthcare providers in a clinic can disrupt patient care and impact organizational stability. A better understanding of the stressors that impact clinical providers can help minimize the number of vacancies, save money, improve the quality of patient care, and ensure the provision of health care services in the community. Results of this project have been used to inform the development of provider support and retention strategies for health centers within the NCHC system.

Authors:

Surekha Appikatla, MPH, Data Informatics Specialist, A.T. Still University

April Alvarez-Corona, MD, Chief Medical Officer, North Country HealthCare Inc.

Ebony Whisenant, MD, Assoc. Prof., Family Med and Public Health, Director, PCTE Fellowship, A. T. Still University, School Of Osteopathic Medicine in Arizona

CP15 - Implementing a Blood Pressure Measurement Protocol to Improve the Diagnosis and Treatment of Hypertension

Poster Type: Research

Track/Topic: A. T. Still University;Quality of Care and Quality Improvement

Research Objectives: Workflow changes that enhance accurate blood pressure measurement can help with the diagnosis and treatment of hypertension and lead to improved health outcomes. The purpose of this project is to improve blood pressure measurement technique and workflow within the Family Health Centers at NYU Langone, a federally qualified health center.

Research Study Design/Methods: Patients with a known diagnosis of hypertension and/or elevated blood pressure visiting the ambulatory care practice have their blood pressure measured using American Heart Association (AHA) recommended patient preparation and measurement techniques. A dashboard to track multiple BP readings when values are outside of recommended BP target ranges was developed and a checklist documented in the electronic medical record is used to monitor adherence with the AHA guidelines in the initial patient triage by the medical assistant.

Research Principal Findings and Quantitative/Qualitative Results: Data analysis shows improved adherence to the AHA recommended patient preparation and measurement techniques within the pilot provider's panel. During the first 16 weeks of project implementation, we noted that patients who had a BP measurement that was initially elevated during triage subsequently had a lower blood pressure when AHA recommended blood pressure measurement techniques were used to guide blood pressure measurement. For example, approximately 32% of patient encounters that showed an elevated blood pressure reading on initial triage were subsequently found to have a normal BP reading when AHA protocol was used to measure the blood pressure.

Research Conclusions on Impact on Health Centers: Accurate blood pressure measurement is essential to the diagnosis and treatment of hypertension. Inaccurate blood pressure measurement may lead to failure to identify patients with hypertension resulting in increased risk for cardiovascular disease, kidney disease, stroke, cognitive decline, and mortality. Alternatively, inaccurate blood pressure measurement may also lead to unfavorable outcomes such as adverse medication side effects, increased risk of falls in the elderly, and an increase in hospitalizations. This quality improvement project demonstrates the feasibility of implementing workflow changes that can enhance accurate blood pressure measurement techniques in an ambulatory care setting.

Authors:

Surekha Appikatla, MPH, Data Informatics Specialist, A.T. Still University

Oksana Genzer, MD, Internal Medicine Primary Care Physician/Adjunct Teaching Instructor, NYU Langone Sunset Park Family Health Center

Ebony Whisenant, MD, Assoc. Prof., Family Med and Public Health, Director, PCTE Fellowship, A. T. Still University, School Of Osteopathic Medicine in Arizona

CP16 - Addressing Food Insecurity by Increasing Awareness of Local Resources in Centreville, Illinois

Poster Type: Innovation

Primary Funding Source: A.T. Still University School of Osteopathic Medicine in Arizona

Category: A. T. Still University; Expanding Access to Care and Other Services; Social Determinants of Health

Issue or Challenge: The city of Centreville, Illinois is a food desert with 80.1% of residents living beyond 1/2 mile from a supermarket or grocery store and 32.0% of housing units report not having access to a vehicle according to the United States Department of Agriculture. This combination has been shown to lead to adverse health outcomes.

Description of Innovation: We created a pamphlet that included information on organizations providing resources within a 5-mile radius of Touchette Regional Hospital located in Centreville, IL. The pamphlet included contact information and websites for food pantries, Southern Illinois Healthcare Foundation (SIHF) clinics, oral health providers, and women's shelters. Given the nature of the COVID-19 pandemic, we ensured each organization was open and available prior to including it in the pamphlet. Information on Eligibility criteria and application instructions for WIC, SNAP, and disability were also included. Also, on the pamphlet was a QR code to an optional internet survey asking for feedback on the pamphlet, leaving room for us to improve this resource in the future. These pamphlets were distributed to the community inside free food packages prepared by the Touchette Regional Hospital Bicycle Food Mission (TRHBFM). TRHBFM is a weekly donation-driven initiative that aims to address food insecurity in the area by preparing and distributing hot, nutritious meals to anyone who requests one. To further help this community, we provided TRHBFM with bundles of disposable face masks to include in food packages with our pamphlet to help provide protection against COVID-19 infection.

Impact or Result: While the larger impact on health outcomes may not fully be known in the short term, the objective of promoting local nutritional and healthcare resources was met. In a 9-week period, approximately 6,000 disposable face masks and 2,000 copies of the pamphlet were distributed along with fresh meals throughout five routes. On average, 222 pamphlets and 666 masks were distributed weekly over 9 weeks. The quantity of distributed pamphlets may not correlate with unique recipients due to overlap in community members who received weekly meals. The health center saw an appreciable growth and increase in donations for the program when comparing week 1 to week 9. Weekly meal production increased from 200 to almost 900 due to a budget increase of \$300/week over that time period. More importantly, as the program grew, increasing numbers of community members volunteered to help those at greatest risk, including the elderly and homeless.

Replicating this Innovation: A similar model could be implemented at other organizations with their own state-specific guidelines. Food insecurity is a common theme across many communities throughout the United States. A TRHBFM-like program could be feasible to implement in other organizations as it requires only a handful of dedicated volunteers and kitchen facilities. In its early stages, the TRHBFM was producing around 200 meals with a \$500 weekly budget for ingredients and supplies. After 12 weeks, the weekly budget had increased to \$800 allowing for the production of nearly 900 meals. Program marketing on social media and the implementation of an online donation system has allowed the program to continue its operations exclusively on donations. We believe such an approach can make this innovation applicable in other organizations.

Author(s):

Victor Huerta, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Teri Nguyen-Guo, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Molly Shipman, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Jeremy Brown, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Karen Chen, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

Jade Jones, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona
Kirstie Mabitad, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona
Syed Raheem, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona
Alexa Stephenson, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona
Aliza Tan, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona
Alan Tran, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

CP17 - Provider Preferences Regarding the Benefits and Challenges of Utilizing Telemedicine

Poster Type: Research

Track/Topic: A. T. Still University

Research Objectives: The utilization of telemedicine in place of in-person appointments has become more common due to the COVID-19 pandemic. By assessing healthcare providers' likes and dislikes of using telemedicine in the greater Portland, Oregon area, a better understanding may be developed to formulate recommendations aimed at improving the telemedicine experience.

Research Study Design/Methods: A survey was developed to assess provider preferences, likes and dislikes of utilizing telemedicine during the COVID-19 pandemic. This survey was sent out via email to providers (MD, DO, NP etc...) at thirty-one sites from three different organizations within the Northwest Regional Primary Care Community Health Centers network. Upon completion of the data collection period, survey responses will be analyzed to determine trends in the benefits, challenges, and effective uses of telemedicine among the participants. This information will then be shared with clinic administrators and participants with the intent of aiding improvement in telemedicine encounters.

Research Principal Findings and Quantitative/Qualitative Results: We have reached out to over 270 providers accessed through employee list-serves at each clinic. Responses will be collected from 3/15/2021 until 04/20/2021. We plan to compile the survey results to examine providers' experiences with telemedicine during the COVID-19 pandemic. Additionally, we intend to identify the types of patient encounters (e.g. dermatologic) that providers have found to be the most effective through telemedicine. We will use this information to provide specific recommendations to the clinic administration in order to inform their decisions regarding the telemedicine process.

Research Conclusions on Impact on Health Centers: With a high volume of patient visits occurring remotely, we wanted to assess providers' satisfaction in providing effective patient-centered care through telemedicine. We will use our survey results to determine what aspects of telemedicine providers identify as effective and ineffective. We will then compile the results and distribute it to all participating clinics in the Northwest Regional Primary Care Community Health Centers with the hope of providing insight to help them make improvements to the telemedicine process.

Authors:

Theresa Chiappe, OMS-II, A.T. Still University School of Osteopathic Medicine in Arizona

CP18 - Piloted Enhancements to a Screening, Brief Intervention, and Referral to Treatment Program in the FQHC Setting

Poster Type: Innovation

Primary Funding Source: The piloted enhancements to the SBIRT workflow are currently funded by a five-year grant from SAMHSA (September 2018 - September 2023)

Category: Behavioral Health Services

Issue or Challenge: Access Community Health Network (ACCESS), one of the largest networks of federally qualified health centers in the nation, has sustained a universal Screening, Brief Intervention, and Referral to Treatment (SBIRT) program across all 35 of its Chicagoland health centers since 2015. Although medical assistants have consistently completed annual patient screenings for alcohol and drug use since the program launched, positivity rates were low compared to known rates in the general population. Furthermore, medical providers struggled to find time during the encounter to prioritize preventive interventions for patients that screen low, albeit positive, on alcohol and drug use screenings.

Description of Innovation: In 2019, ACCESS began to pilot an enhanced SBIRT program that embeds a designated SBIRT paraprofessional, or Community Health Specialist (CHS), at each of five pilot health centers. The CHS is integrated into the care team to screen patients for alcohol and substance use, conduct a brief intervention in the form of a motivational interview with patients with potentially risky use, and facilitate referrals to integrated behavioral health services, onsite medication-assisted recovery (MAR), and external treatment services, as appropriate.

Impact or Result: In the first two years of the pilot program, the ability to detect positive patients at SBIRT pilot sites greatly improved. ACCESS CHSs screened over 5,800 patients. Among patients that screened positive (19%), over half (55%) indicated marijuana use at least once in the past thirty days, and rates of daily marijuana use exceeded that of daily alcohol use (24% of positive-screened patients compared to 11%). CHSs consistently delivered motivational interviews to over 99% of patients identified for SBIRT services. In addition, a higher-than-expected number of SBIRT patients, including negative-screened patients, met with an ACCESS behavioral health consultant within six months of their initial CHS encounter.

Replicating this Innovation: ACCESS has only piloted the enhanced SBIRT workflow within our own organization. However, thorough evaluation of our SBIRT CHS training activities found important take-aways for other organizations interested in integrating similar roles into their care team. To prepare CHSs to deliver consistent and effective motivational interviews, we found that trainings must be spaced out gradually over multiple months to allow time for staff to test new concepts in the field between trainings. Effective training must also include both interactive group activities (role plays, peer feedback, analyzing videos), and individual coaching. Trainings at ACCESS were conducted by a member of the Motivational Interviewing Network of Trainers (MINT).

Author(s):

Amber Kraft, PhD, Evaluation Specialist, Access Community Health Network

CP19 - Implementation of an Outpatient Alcohol Withdrawal Protocol at an Urban Community Health Center

Poster Type: Innovation

Category: Behavioral Health Services

Issue or Challenge: The World Health Organization reports alcohol use disorder (AUD) impacts up to 5% of people worldwide. Of those with a moderate to severe alcohol use disorder, 50% will experience withdrawal symptoms which can include anxiety, sleep disturbance, tremors, seizures, delirium tremens, and death. A barrier to treatment for individuals with an AUD is the lack of detoxification services to assist in safely managing withdrawal symptoms. Outpatient treatment of mild to moderate withdrawal has been demonstrated to be safe, patient-centered, cost effective and is supported by American Society of Addiction Medicine guidelines but was not widely available in our setting.

Description of Innovation: With the intent to reduce barriers to safe treatment for lower risk patients with AUD who require medication for withdrawal, the medication assisted treatment (MAT) team in our CHC piloted an outpatient withdrawal management protocol. The protocol, which is being published elsewhere, incorporated the freely available PAWSS (Prediction of Alcohol Withdrawal Severity Scale) and CIWA (Clinical Institute Withdrawal Assessment) along with several other characteristics to risk-stratify patients who were interested in stopping drinking. Eligibility was determined for outpatient treatment (with non-benzodiazepine medications or benzodiazepine medications) versus referral to higher level of care. Providers and staff were educated about the outpatient treatment protocol at a staff meeting and patients who were identified as wanting to stop drinking were referred to our integrated addiction counselor and MAT providers for an intake visit. After initiation of the treatment protocol, daily follow up visits (either in person or telehealth) were scheduled for medication and counseling as well as a one week follow up visit to initiate maintenance treatment. Our clinic developed note templates for our electronic medical record that incorporated decision aids and we developed patient handouts and materials.

Impact or Result: Since implementing this protocol in our clinic in August of 2020 a total of 19 patients have been referred for assistance with stopping drinking. 15 of these patients were successfully able to stop drinking during the outpatient withdrawal protocol and 14 were transitioned onto maintenance medication for alcohol use disorder during follow up in our addiction clinic. Overall, we have also had a notable increase in patients receiving maintenance medication for alcohol use disorder. In the 2 quarters preceding implementation, our clinic averaged 43 patients receiving oral naltrexone, 6 receiving IM-depo naltrexone, and 7 receiving oral acamprosate. In the 2 quarters since implementation, our clinic averaged 60 patients receiving oral naltrexone, 12 receiving IM-depo naltrexone and 13 receiving acamprosate representing a 40%, 100% and 86% increase in prescriptions for maintenance medications treating alcohol use disorder.

Replicating this Innovation: The use of an algorithm and note template provides a framework to help guide treatment decisions in the outpatient setting. It has successfully been used by providers throughout our clinic and outside of the MAT clinic given the straightforward guidance. It could easily be replicated in other organizations.

Author(s):

Daniel White, MD, Assistant Professor, Denver Health

Jessica Cram, LAC, LPCC, Licensed Addiction Counselor, Denver Health

Jessica Bull, MD, Assistant Professor, Denver Health and Hospital Authority

Raeanna Simcoe, MD, Senior Instructor, Denver Health and Hospital Authority

CP20 - 2019 Uniform Data System Report: An Analysis of Asian American-, Native Hawaiian-, and Pacific Islander-Serving Health Centers

Poster Type: Research

Track/Topic: Demonstrating Value;Expanding Access to Care and Other Services;Improving Care for Special Populations;Quality of Care and Quality Improvement;Social Determinants of Health;Workforce

Research Objectives: Asian American (AAs), Native Hawaiian (NHs), and Pacific Islanders (PIs) are the fastest-growing major racial or ethnic group in the United States and its territories. AAPCHO analyzed the UDS data of AA-, NH-, and PI-serving health centers to assess health disparities, workforce development trends, and recommendations to improve population health.

Research Study Design/Methods: AAPCHO analyzed health center and patient data using the Uniform Data System (UDS), an annual reporting system by the Health Resources and Services Administration (HRSA) for health centers. AAPCHO identified AA-, NH-, and PI-serving health centers as the top 10% of health centers in terms of the number of AA, NH, and PI patients served at the health center in 2019 and NH- and PI-serving health centers as health centers that served greater or equal to 1,000 NH and PI patients combined in 2019.

Research Principal Findings and Quantitative/Qualitative Results: On average, AA-, NH-, and PI-serving and NH- and PI-serving health centers had more full-time Enabling Services staff than health centers nationally. Compared to the national health center average, both AA-, and PI-serving and NH- and PI-serving health centers reported a higher proportion of limited English proficient, low-income, Medicaid, and publicly insured patients. However, AA-, and PI-serving and NH- and PI-serving health centers demonstrated higher rates of childhood immunization, cervical cancer screening, and controlled hypertension than the national average.

Research Conclusions on Impact on Health Centers: Overall, AA-, NH-, and PI-serving and NH- and PI-serving health centers had a higher proportion of patients with social risk factors, but demonstrated higher quality of care in several areas. The higher quality of care may be attributable to the health centers' higher rates of Enabling Services staff. These results inform how health centers serving AA, NH, and PI populations can prioritize their resources. Investing in more Enabling Services staff at AA-, and PI-serving and NH- and PI-serving health centers may decrease health disparities for AA, and PI patients.

Authors:

Sakura Miyazaki, Program Manager, Training and Technical Assistance, AAPCHO

Vivian Li, MS, Research Analyst, AAPCHO

Joe Lee, MSHA, Director of Strategic Initiatives and Partnerships, Association of Asian Pacific Community Health Organizations

Albert Ayson, Associate Director, Training and Technical Assistance, AAPCHO

CP21 - New Immigrant Case Management: Responding to the Southwest Border Crisis in a New Jersey FQHC

Poster Type: Innovation

Category: Expanding Access to Care and Other Services; Patient and Community Engagement; Public Health Crises; Social Determinants of Health; Workforce

Issue or Challenge: Zufall Health Center (ZHC) in New Jersey has seen hundreds of Central American child immigrants arrive over the past decade to our centers. These children are an extremely high-risk cohort, with particular need for assistance with school enrollment and linkage to legal services. While we have dedicated case management services for other high-risk populations (seniors, patients with mental illness or HIV), we have not had this available to new immigrant children and families. Using Americorps staff, Zufall has begun a program to identify new immigrant children within our practices and connect them with legal and social services.

Description of Innovation: In response to ongoing and increasing numbers of recently arrived migrant children, Zufall has begun a “New Patient Assistance” (NPA) program to provide case management to unaccompanied minors. Most significantly, the program has integrated a legal services linkage process where children are connected with pro bono or low-cost legal immigration services that can provide representation. There is no constitutional right to representation in immigration court, and it has been clearly shown that children who have representation are far more likely to have successful immigration cases. Many of these patients are not yet registered for public school, which is necessary for a successful asylum case, as well as for ongoing child development. NPA case managers assist with school registration, as well as with applications for Pandemic Rental Assistance; the Special Program for Women, Infants, and Children (WIC); and hospital charity care, by serving as translators and assisting with technology. Additionally, information is provided about local food pantries and other social services, and interested patients are referred to Zufall’s behavioral health services, as well as other medical and dental services as needed.

Impact or Result: Since the program was initiated in September 2020, NPA case managers have worked with 53 unaccompanied minors and 205 families. This has resulted in the connection of 59 of these patients with immigration attorneys and the registration of 8 children for public school. All patients have been provided information on local food pantries and social service programs. Legal services were reviewed with all families, and referral information was provided if a direct referral connection was not made. Given the current several-year wait time for resolution of typical immigration cases, it is difficult to assess the effect of this program on success within the court system. Regardless, the NPA referral process continues to wield considerable and measurable effect in breaking down barriers that our newly arrived immigrant children face. It is imperative that innovative and ground level programs continue to develop and evolve to meet the needs of this high-risk population.

Replicating this Innovation: This program is easily replicable and scalable within other health centers. FQHCs have a proven track record for case management, and understand the complex interplay of social factors that impact immigrant health. Furthermore, integrated and Trauma Informed Care that is offered at FQHCs make them an ideal location for this type of innovation. Medical-legal partnerships should be considered as standard enabling services offered at FQHCs. Americorps volunteers have been well placed to do this work in our organization.

Author(s):

Douglas Bishop, MD, Family Medicine Physician, Zufall Health Center

CP22 - Identifying COVID-19 Mortality and Social Deprivation Hot Spots and Exploring Opportunities for Health Center Response

Poster Type: Research

Track/Topic: Expanding Access to Care and Other Services;Public Health Crises;Social Determinants of Health

Research Objectives: This research has two aims: (1) to identify priority areas based on high levels of social deprivation and COVID-19 mortality and COVID-19 mortality “hot spots” – which are clusters of high rates of COVID-19 mortality; and (2) to identify health centers located in priority areas.

Research Study Design/Methods: Data sources include COVID-19 mortality from USA Facts, social deprivation from the Robert Graham Center, and health center awardee patient characteristics from UDS. Bayesian smoothing of COVID-19 mortality was used to identify counties in the top quintile for COVID-19 mortality per capita. Local Moran’s I analysis was then used to identify counties within geographic “hot spots.” Priority areas were defined as counties in the top quintile for COVID-19 mortality rates and social deprivation, or those identified as COVID-19 mortality “hot spots.” Geographic Information Systems (GIS) were then used to overlay health center service delivery sites on priority counties.

Research Principal Findings and Quantitative/Qualitative Results: We identified 504 priority counties that had high rates of COVID-19 mortality and social deprivation, or were part of COVID-19 mortality “hot spot.” Most priority counties are located in rural areas in Texas, the Southeast (MS, GA, AL, LA), and Great Plains States (KS, IA, ND, SD), while several are within large urban centers (New York City). Priority counties include more than 250 Health Center Program awardees, 1,660 service delivery sites, and 6.5 million patients. Health centers in priority counties have higher percentages of patients that are Black, uninsured, homeless, and in public housing.

Research Conclusions on Impact on Health Centers: The impact of COVID-19 has been significant for health centers across the U.S. However, health centers located in the hardest hit areas would likely benefit most from having increased access to COVID-19 vaccinations via health centers and may have experienced the largest declines in “routine” health care utilization, including having large numbers of patients forgo critical preventive care such as cancer screenings. This research identifies health centers located in areas most impacted by COVID-19 and identifies opportunities to target resources to these health centers regarding preventive care, COVID-19 immunizations, and other patient outreach.

Authors:

Michael Topmiller, PhD, Health GIS Research Specialist, American Academy of Family Physicians
Jennifer Rankin, PhD, Sr. Manager Research & Product Services, American Academy of Family Physicians
Jessica McCann, MA, User Engagement Specialist, American Academy of Family Physicians
Jene Grandmont, MA, Sr. Manager Application & Data Services, American Academy of Family Physicians
David Grolling, MS, GIS Strategist, American Academy of Family Physicians
Mark Carrozza, MA, Director, American Academy of Family Physicians

CP23 - Quality Improvement Network for Contraceptive Access (QINCA) 2.0: Integrating Reproductive Justice Through a Contraceptive Access Quality Improvement Program

Poster Type: Innovation

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

Issue or Challenge: Access to high-quality, patient-centered contraceptive care is key to supporting individuals' human right to make informed and autonomous decisions about their reproductive health. However, communities of color, LGBTQ+ and low-income communities frequently report receiving coercive or biased contraceptive counseling and reproductive health care. It is critical that clinical care settings address these inequities by intentionally implementing care practices that center contraceptive choice and reproductive autonomy. To this end, QINCA 2.0 supported NYC-based health care setting in implementing clinical and operational improvements to increase contraceptive access for all, specifically those at highest risk for reproductive coercion and/or discrimination.

Description of Innovation: QINCA 2.0, a 12-month quality improvement learning collaborative (QILC), was launched in 2019 in partnership between the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) and Public Health Solutions (PHS) to improve the quality of contraceptive care in primary care, post-abortion, and postpartum settings in NYC. QINCA 2.0 is based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) model and guided by the sexual and reproductive justice (SRJ) framework, developed by women of color, which prioritizes individual choice and bodily autonomy within the context of historical events, lived experiences, sexualities, and social conditions. To support site-based improvements in contraceptive care, PHS and NYC DOHMH developed a quality improvement (QI) toolkit, including a set of SRJ-informed best practices called the Four Steps to Contraceptive Access. The Four Steps include assessing contraceptive need, ensuring same-day access, reducing cost as a barrier, and documenting care. QINCA 2.0 also applied a set of SRJ-aligned performance measures adapted from existing validated measures of contraceptive care, including the Person-Centered Contraceptive Counseling (PCCC) measure, that support monitoring of progress across the Four Steps. Throughout the collaborative, participating sites were provided targeted training, coaching and technical assistance on the Four Steps, the SRJ framework, patient-centered care strategies, and fiscal best practices to ensure sustainability of contraceptive care programs. Participating sites tested and implemented improvements using Plan-Do-Study-Act cycles, data collection on key measures, and collaboration with other teams at learning sessions. Following the start of COVID-19, activities were adapted to integrate a telehealth focus.

Impact or Result: Participants improved their setting's contraceptive care practices through collaborative activities and site-based QI initiatives. Successes included: the introduction of new contraceptive services, integration of SRJ principles into care practices, optimization of contraceptive workflows, and implementation of a contraceptive counseling patient experience survey including the PCCC measure. Additionally, a total of 247 staff across seven health care organizations participated in an introductory training on SRH services and the SRJ framework, among other collaborative trainings. Results of participants' pre-post self-assessment, which measured implementation of the Four Steps, revealed that average scores among the six completing teams increased by 27%, with the greatest improvements seen in sub-elements related to staff training, on-site stocking of contraceptives, updating policies and procedures, electronic health record (EHR) configuration, and standardized measure reports. Findings from the PCCC measure are inconclusive due to the impact of COVID-19 on service provision and challenges related to data collection from telehealth visits.

Replicating this Innovation: QINCA 2.0 materials are available upon request. Health care organizations can apply the QI framework used in QINCA 2.0 to design and implement similar quality improvements. Review of SRJ literature and engagement of local SRJ experts is foundational to this work and should inform all stages of planning and implementation. QI resources are available to support the application of this model, through IHI for example, and many health care organizations retain QI staff that can guide improvement efforts. Key first steps include assessing current clinical and operational practices, identifying specific areas for improvement, addressing gaps in staff knowledge and skill through training, and establishing infrastructure to support ongoing improvements, such as EHR re-configuration to document care and the adoption of key indicators of contraceptive care quality, including the PCCC measure. Early

engagement of senior leadership and establishing a strong improvement team are also critical to the success of QI initiatives.

Author(s):

Julia Keegan, Collaborative Manager, Sexual and Reproductive Health Capacity Building, Public Health Solutions

Dayana Bermudez, Program Manager, Sexual and Reproductive Health Capacity Building, Public Health Solutions

Hestia Rojas, MPH, Quality Improvement Specialist, Public Health Solutions

Christina Ortiz, MPH, Training Manager, Sexual and Reproductive Health Capacity Building, Public Health Solutions

Allyna Steinberg, MPH, MAmSAT, Deputy Director, Sexual and Reproductive Health (SRH) Initiatives, NYC Department of Health and Mental Hygiene

Lindsey Gibson, MPH, Sexual and Reproductive Health Analyst, NYC Department of Health and Mental Hygiene

Kathryn Iglehart, MPH, Assistant Director, Sexual and Reproductive Health Capacity Building, Public Health Solutions

Joslyn Levy, MPH, President, Joslyn Levy & Associates, LLC

Natalie Tobier, MPH, LCSW, Senior Director, Sexual and Reproductive Health, Public Health Solutions

CP24 - The Influence of Meal Delivery on Engagement in a Digital Health Coaching Program

Poster Type: Research

Track/Topic: Expanding Access to Care and Other Services

Research Objectives: Digital health coaching (DHC) demonstrates positive outcomes among adults with type 2 diabetes (T2DM), yet engagement rates are often low, particularly among underserved populations with health-related barriers including food insecurity. This retrospective review explored how inclusion of meal delivery influences DHC engagement, focusing on transition from enrollment to program participation.

Research Study Design/Methods: We compared participant data from two payer-provided 12-week T2DM DHC programs. Group 1 (n=597) includes adults with T2DM, largely recruited from financially- and food-insecure communities, who were provided DHC + biweekly meal delivery; Group 2 (n=448) includes adults with T2DM who received DHC only. Both programs provide behavioral and psychosocial support delivered by phone, text and/or email. This analysis focuses on retention between enrollment and the first DHC call. Descriptive statistics were used to analyze data including participant retention, demographics and baseline patient reported outcomes (diet, mental health, overall physical health, financial toxicity).

Research Principal Findings and Quantitative/Qualitative Results: Groups 1 and 2 had similar mean age (53 vs. 58), racial/ethnic backgrounds (44% vs. 41% nonwhite) and baseline A1cs (7.23% vs. 7.64%). Diabetes distress (2.80 vs. 2.68), depression (1.43 vs. 0.97), stress (5.32 vs. 5.04), and financial toxicity (20.21 vs. 24.60) were higher in Group 1. Group 1 also reported poorer overall physical health (41.57 vs. 44.46) and consumed fewer weekly healthy meals (5.72 vs. 7.09). Retention from enrollment to the first call was significantly higher in Group 1 compared with Group 2 (93% vs. 75%; p<.0001), representing improved engagement from DHC orientation to participation.

Research Conclusions on Impact on Health Centers: These descriptive data provide insights into the role of meal delivery services in DHC program retention. Individuals with T2DM experiencing barriers to health including food insecurity, as measured by the 10-item USDA Adult Food Security Survey Module, reported poorer diet, worse financial toxicity and increased mental and physical health needs. These real-world outcomes suggest food delivery may incentivize participation in a DHC program, which in turn may improve patient reported outcomes and health related quality of life. This may be beneficial for higher risk and underserved T2DM populations who are commonly served by federally qualified health centers.

Authors:

Megan Martin, MPH, Director, Strategic Partnerships and Programs, Pack Health

Blakely O'Connor, PhD, Associate Director, Research/HEOR, Pack Health

Vanessa Tran, MS, Analyst, Pack Health

Matt Allison, Director, Quality Improvement, Pack Health

Dhiren Patel, PharmD, Senior Vice President, Pack Health

CP25 - CareSouth Carolina MOBYs - Mobile Vehicles to Provide and Enhance Services for Our Patients

Poster Type: Innovation

Category: Expanding Access to Care and Other Services

Issue or Challenge: We saw the COVID-19 Testing need facing us with a rural population in our 5 county service area with a total population of 185,693. We heard about using mobile vehicles that could be outfitted for testing. After choosing one, we designed the vehicle to not only be used for COVID-19 testing but though these could be used to bring needed services to our patients outside of the existing medical centers we have. We purchased 5 units, one for each of our 5 counties in rural SC that we serve.

Description of Innovation: The MOBY vehicles are designed to offer direct patient outreach, lab testing and collection, vaccine administration, and future closing of patient medical gaps in care. Direct patient outreach is offered by the quick setup at almost any location. The vehicle is similar to an ambulance but its inside configuration was designed to maximize space. There is a side window that pops out and a step included that allows patients to step up outside the vehicle and have certain lab tests collected while standing. The inside of the vehicle is equipped with 2 seats for staffing, one of which is at the back with a laboratory workstation. There are numerous cabinets on both sides to allow for storage of all supplies. There is both a vaccine-grade refrigerator and freezer on board to store both vaccines, medications, and lab reagents. The vehicle has internet access onboard for EMR access. The outside of the vehicle includes a canopy that automatically rolls out to provide shade and shelter for patients and staff while working. The vehicle is staffed with a phlebotomist and a Community Health Worker, and have included nurses and providers to see patients in the parking lots where the MOBY is setup when these staff are available.

Impact or Result: Our MOBY vehicles started providing services with 1 MOBY starting in October of 2020. 3 additional MOBY vehicles started providing services in November and the 5th MOBY arrived in January. Our sites include Division of Social Services, City Chambers of Commerce, Coker College Athletic Department, Churches, Libraries, YMCAs, Community Colleges, Dollar Generals, Grocery Stores, Community Centers, Convenient Stores, Free Medical Clinics, Apartment Complexes, and Schools. To date, we have administered over 7900 COVID-19 tests in our communities. We have just started offering vaccines in the last week on our MOBY vehicles and given over 200 vaccines in our communities.

Replicating this Innovation: The plans, videos, and pictures for our MOBY vehicles can and will be shared with anyone or any center that would like to see these. The vehicle and the staffing are the two largest challenges with this type of innovation. We also have a YouTube video showing the MOBY in action and a tour of the vehicle. Here is the link to the YouTube video <https://www.youtube.com/watch?v=NSb7Xh1Zlz8>

Author(s):

Randall Carlyle, MPA, Chief Quality Officer, CareSouth Carolina

CP26 - A Model for Patient Outreach to Address Outstanding Preventive and Maintenance Health Care During the COVID-19 Pandemic

Poster Type: Innovation

Category: Expanding Access to Care and Other Services

Issue or Challenge: The COVID-19 pandemic limited access to routine healthcare including cancer screenings, blood pressure checks, diabetes exams, and others. Of 8 metrics for preventive and maintenance healthcare tracked by Denver Health for Lowry Family Health Center, decreased scores were noted across the board from January 2020 to May 2020. The challenge was to enhance access to these necessary medical services for an underserved population and to produce better health outcomes by re-engaging patients in their preventive and maintenance healthcare in safe ways during the pandemic.

Description of Innovation: A patient outreach strategy was developed to address patient care gaps based on 8 metrics routinely tracked by Denver Health. These 8 metrics were considered suitable for outreach because they involved completion of a lab or screening test or scheduling an in-person visit with a provider. The metrics address diabetes (A1c and nephropathy), hypertension, breast/colon/cervical cancer screening, pediatric vaccinations, and asthma. A calendar was developed which listed the metric of focus for each week and included clickable links to standard work. The outreaches were done by medical assistants and included accessing a report for overdue health maintenance in the electric record, placing orders for labs or screening exams, and calling or sending a letter to patients with instructions for scheduling a visit or obtaining tests. Progress was evaluated using a tracking function in the electronic record for recent outreaches as well as change in the clinic's success rates on the metrics over time.

Impact or Result: 752 individual outreaches were completed between June and December 2020. Rates of success for some metrics improved over that period including diabetic nephropathy testing (+1.2%), cervical cancer screening (+1.4%), and asthma control (+2.8%). However, rates of success decreased in some metrics including diabetic A1c control (-2.7%), breast cancer screening (-1.3%), hypertension control (-0.9%), pediatric vaccinations (-0.8%), and colorectal cancer screening (-0.5%).

Replicating this Innovation: The outreach calendar model would easily replicate. After choosing the healthcare gaps to be addressed, one would need a reliable way to determine those patients that require outreach and a way to track who has been outreached and when.

Author(s):

Raeanna Simcoe, MD, Senior Instructor, Denver Health and Hospital Authority

Jessica Bull, MD, Assistant Professor, Denver Health and Hospital Authority

Zita Fenner, RN, Nurse Program Manager, Denver Health and Hospital Authority

CP27 - The Role of Health Equity Navigators in Improving Access to COVID-19 Vaccines in Latinx Communities Through Community Health Centers

Poster Type: Innovation

Category: Expanding Access to Care and Other Services; Patient and Community Engagement

Issue or Challenge: Vaccine hesitancy is one of the most cited reasons to explain low COVID-19 vaccine uptake among Latinx communities in the United States. AltaMed Health Services is one of the nation's largest Federally Qualified Health Centers, serving more than 300,000 predominantly Latinx patients in medically underserved communities of southern California. Through this program, we addressed challenges associated with access to vaccine information and appointments for working-class Latinx patients and community members in Orange County, California. Through this approach, we successfully removed barriers that presented initial sources of hesitancy among our patient population, including disinformation and misinformation.

Description of Innovation: Starting in February 2021, AltaMed embarked on a demonstration project to test its Health Equity Navigator model's effectiveness in improving access to COVID-19 vaccines in its service area. The program is part of the AltaMed Institute for Health Equity's Undergraduate Medical Education department. It is designed to provide clinical experience to pre-med and other aspiring health professionals. Four Health Equity Navigator positions were pivoted to focus on COVID-19 vaccine engagement, to identify challenges related to underlying social determinants of health, and ultimately to help overcome these challenges. The innovation included three phases. Phase 1: Navigator-led inbound and outbound calls to identified panel of patients meeting initial vaccine eligibility of ages 65+. Phase 2: Inbound calls from patients and community members and outbound calls to non-AltaMed patients based on interests lists provided by community partners. Phase 3: Inbound calls and deployment of a partner community program to streamline appointments for non-patients. During these engagements, health navigators provide information, education, and support, as well as direct assistance to individuals in making appointments for their COVID-19 vaccine.

Impact or Result: Results of our Health Equity Navigator pilot project to increase access to vaccines are as follows: Providing 2,600+ vaccines to highly-vulnerable community members, approximately 50% of whom did not have a medical home. Development and integration of a model to expedite vaccine access for non-clinic patients who lived in our clinic's service area through community partnerships. Development of a model that can scale medical education programs into a workforce that is ready to advance health equity for pandemic response and recovery. Effectively overcoming vaccine hesitancy by addressing information gaps through culturally concordant education, information, and direct assistance with access.

Replicating this Innovation: Create a pipeline of health navigators who know the community and also have familiarity with navigating systems. This will make it easier for them to address communities' concerns, in language and terms that resonate with the community. If it is not possible to create a specific pipeline of health navigators, work within the models that already exist in the clinic: community health workers, other forms of patient navigators, and provide specific training on vaccine access and major questions so they can support community members in their process of scheduling.

Author(s):

Gloria Montiel, PhD, Researcher, AltaMed Health Services Corporation

Erick Leyva, Project Coordinator for Undergraduate Medical Education, AltaMed Health Services Corporation

CP28 - Addressing Food Insecurity During the Pandemic

Poster Type: Innovation

Category: Expanding Access to Care and Other Services; Patient and Community Engagement

Issue or Challenge: Bronx Community Health Network's Community Health Workers (CHWs) help identify and refer clients (in clinical and community settings) with social needs to community resources. Historically, food insecurity has been one of the most urgent and common needs our clients face. 1 in 5 clients screened for social needs are food insecure. Referrals of food insecure clients to food resources increased from 700 (2019) to 1,097 (2020). As the pandemic began and stay at home orders were issued, CBOs struggled to stay open and COVID-19 continued to spread, community members found themselves struggling to meet their basic needs.

Description of Innovation: BCHN health centers systematically screen patients for SDH needs (among which food insecurity) and refer them to CHWs who in turn help address patients' needs and connect them to resources. At the onset of the Covid-19 pandemic, food insecurity needs sharply increased as community members lost income, were unable to go out to get food, and food resources became overwhelmed. In response to the growing food need, BCHN launched a food delivery initiative, through our mobile van and partnership with a local food pantry. CHWs and other care team members (i.e. providers and social workers) identified food insecure clients. If those community members met the eligibility criteria (i.e. elderly, diagnosed with underlying condition, or homebound), they were enrolled in the food delivery initiative. Once enrolled, families received at least one food delivery, connected to additional food resources to supplement the amount of food received, were screened for additional needs and connected to resources (i.e. diapers), and were provided assistance with navigating the internet and submitting benefit applications through newly launched online application portals.

Impact or Result: BCHN is committed to eliminating health disparities among underserved communities in the Bronx. Our mission is to increase access to quality health care, conduct culturally sensitive health education sessions, spearhead community health initiatives, and connect community members to resources to address social determinants of health (SDH). Specific to food insecurity, our CHWs assisted over 700 Bronx families with SNAP enrollment, food pantry or hot meal referrals; increasing to 1,097 in 2020. We have delivered food to over 200 unique families, totaling to over 1,000 Bronxites (one delivery per month, per family), serving every zip code in the Bronx. Through our program we screen for and connect community members to social support services such as food resources, benefits applications, help with housing and utilities, employment, and legal services; provides chronic disease management and healthy lifestyle education; connects to health insurance and quality primary care.

Replicating this Innovation: The goal of this initiative is to address the increasing food insecurity of vulnerable populations in the Bronx. BCHN will replicate our existing food delivery initiative by increasing partnerships to other local food pantries throughout the Bronx. The replication of our program will allow us to have a broader reach and increase the volume of food and the number of people we serve. Additionally, we will be able to link all food delivery recipients to other food and social service resources that can help address the root causes of food insecurity (i.e. job placement, job skills, benefits access etc.)

Author(s):

Patrizia Bernard, MPH, Community Health Worker Supervisor, Bronx Community Health Network

Tashi Chodon, MPH, BSN, Director, Programs, Bronx Community Health Network, Inc.

Renee Whiskey, MPH, MCCHES, AE-C, Community Health Programs Developer, Bronx Community Health Network, Inc.

Damiris Perez, MPA, Grants and Program Developer, Bronx Community Health Network, Inc.

CP29 - Innovations to Sustain HIV and Hepatitis C Screening and Linkage to Care Efforts: Point-of-Care Testing Through Street Medicine Teams

Poster Type: Innovation

Primary Funding Source: Gilead FOCUS Grant and LA Christian Health Centers, Street Medicine Funding

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: Over the course of 2020 we saw a 40% decrease overall in Hepatitis C and HIV screenings as patient visits decreased and the clinic shifted to more telehealth visits. Our linkage to care rates remained stable at 96% for Hep C and 91% for HIV. To sustain our Hep C and HIV screening, diagnosis, and linkage to care efforts during the pandemic, we began testing patients for HIV and HCV in non-traditional settings, offering point-of-care screenings both in and outside the clinic in shelters, through street medicine teams, and a mobile van testing unit in collaboration with LA County DPH.

Description of Innovation: LA Christian Health Centers is a federally qualified health center founded in the 1990's with 2 full-time and 13 part-time satellite sites. Our mission is to serve and improve access to care for the homeless population and those living in public housing. We have performed upwards of 800 point-of-care tests to date in the community as part of our innovation to sustain Hep C and HIV screenings and linkage to care efforts. Planning involved determining a funding source for testing, collaborating with the Los Angeles County Department of Public Health in order to secure access to the mobile van testing unit, establishing workflows and clinical guidelines for screening and linkage, and supplying to and training street medicine teams for use of rapid test and implementation of screening workflows. The point-of-care tests are performed by roaming street medicine teams throughout the week and weekly testing at different locations in the community using a mobile van unit through Los Angeles County DPH. Upon detection of rapid positives on the mobile van testing unit or by street medicine teams, we draw confirmatory labs same day and schedule patient appointments for linkage to care through our HIV/Hepatitis C Care Coordinator.

Impact or Result: We have detected 50 positive Hepatitis C patients at a 12.6% seropositivity rate and 6 positive HIV patients at a 1.38% positivity rate with 67% linked to care and 2 started on rapid start ART therapy day of. All positive patients are offered confirmatory blood-based screenings in the street medicine, mobile van, or clinic settings and scheduled for linkage to care appointments to discuss diagnosis and further care. 32% of the Hepatitis C positives have been new positives. Of these new positives, we have confirmed 43% and are currently working to link the confirmed positives to care. Testing patients in non-traditional settings has allowed us to uncover both new and known Hep C and HIV positive individuals, engage with patients in a familiar setting, and increase access to healthcare services; this has also changed the way we outreach to patients, emphasizing meeting patients where they are at.

Replicating this Innovation: Replication of these innovations in other organizations would require a similar expansion of street medicine teams and outreach, utilizing teams of healthcare providers, nurses, medical assistants, and a care coordinator to facilitate screening and linkage to care efforts from street medicine to clinic setting. These efforts would additionally require close community partnerships with organizations providing similar community-based and social service-related resources and engaging regularly with patients in street-based settings, such as case management and housing navigation teams. Finally, a means of processing, tracking, and analyzing through EMR via cooperation with IT specialists in your organization, would be an important development to allow for the successful implementation of this innovation.

Author(s):

Kathryn Fulton, HIV and Hepatitis C Care Coordinator, Los Angeles Christian Health Centers

CP30 - Addressing the Maternal Mortality Crisis in the Ambulatory Setting: A Quality Improvement Approach

Poster Type: Research

Track/Topic: Patient and Community Engagement;Public Health Crises;Quality of Care and Quality Improvement

Research Objectives: The Chicago Collaborative for Maternal Health, led by AllianceChicago and EverThrive Illinois, aims to improve maternal health via quality improvement in ambulatory care, community engagement, and policy advocacy. AllianceChicago is leading QI, a population health model seeking to increase the percentage of high-risk patients linked to primary care after delivery.

Research Study Design/Methods: The CCMH QI collaborative reflects the Institute for Healthcare Improvement's (IHI) "Collaborative Model for Achieving Breakthrough Improvement," which includes the following activities: topic selection; expert recruitment; participating organization recruitment; action periods; and learning sessions. AllianceChicago will conduct pre- and post- comparison of the quality improvement intervention: de-identified, aggregate baseline data collection to compare with deidentified, aggregate post-intervention data collection along with analysis of a small subset of patient level, de-identified data from AllianceChicago participating sites. Each clinic will pilot the intervention with their own designated high-risk criteria based on their patient population.

Research Principal Findings and Quantitative/Qualitative Results: AllianceChicago engaged thirteen partners to inform QI, with seven implementing. We conducted baseline data collection on structure, process, and outcome measures. Structure and process measures include: high-risk criteria defined/implemented; care coordination process identified/implemented; number of staff trained; and number of locations of care implemented. At baseline, three sites had existing high-risk criteria and care coordination processes; no sites had processes linking to primary care. All sites are implementing in at least one location of care with staff trainings in process. The primary outcome measure is the percentage of high-risk patients connected to primary care. The aggregate baseline was 26 percent.

Research Conclusions on Impact on Health Centers: According to the Chicago Department of Public Health's report, "Maternal Morbidity and Mortality in Chicago," non-Hispanic Black birthing people have the highest rates of maternal morbidity and mortality in Chicago. This is reflective of data at state/national levels. The baseline data is clear there are opportunities for improvement in linking high-risk prenatal patients to primary care after delivery, a crucial time to impact outcomes. From initial learnings, AllianceChicago has developed an algorithm to define and identify high-risk patients to coordinate care, which supports health center capacity and aims for this pilot to be sustainable, replicable, and scalable.

Authors:

Jena Wallander Germkow, MPH, BSN, RN, Clinical Research Manager, AllianceChicago

CP31 - Improving Health Outcomes in Vulnerable Populations: The Medical-Legal-Partnership Colorado's (MLP-CO's) Experience

Poster Type: Innovation

Category: Patient and Community Engagement; Social Determinants of Health

Issue or Challenge: Social determinants of health(SDH) may have a greater effect on health outcomes than medical interventions, yet healthcare providers are not adequately equipped to address them. Medical legal partnerships (MLPs) add legal professionals, trained specifically to tackle these issues, to the healthcare team. The latest reviews of the evidence document how the MLP addresses the quadruple aim (patient and provider experience, costs, health outcomes). However, evaluations on health outcomes and healthcare utilization remain scarce hampering the wide adoption of this strategy. We describe the pre and post evaluation of the MLP-CO's impact on health outcomes, healthcare utilization, legal needs and satisfaction.

Description of Innovation: Unlike other civil legal aid organizations MLP Colorado operates on-site and in coordination with Salud Family Health Center in Commerce City, CO. Under this fully-integrated model, MLP attorneys act as one piece of the care team alongside services like primary care, behavioral health, dental, pharmacy, and care management. Patients are then screened by the MLP-CO lawyers for I-HELP legal needs (Income, Housing, Employment, Legal status, Personal needs). Clients with needs other than I-HELP are referred to local organizations providing legal aid. From 2015-2020, the MLP-CO completed 223 legal cases while 185 cases remained open (average 68 clients/year). Since its inception, evaluation of health outcomes and healthcare utilization (especially emergency department visits) of the MLP-CO clients was a priority. Upon MLP-CO enrollment (BASELINE), clients are assessed for: 1)overall mental and physical health, using validated questions from SF-36; 2)healthcare utilization; 3)legal needs. Six months post-enrollment (FOLLOW-UP), clients are contacted by phone to assess the same items, as well as satisfaction with MLP-CO services, and perception of the MLP-CO's impact on their healthcare experience. Interviews were conducted in the client's preferred language.

Impact or Result: Overall, 115 clients (115/193, 59.6%) responded the surveys. Most were low-income women. Reasons for legal assistance were: immigration status(48.7%), income/benefits(28.7%), personal/family stability(16.7%), housing(5.3%), and education(0.7%). Legal success rate was 84.5%. Over 86% of clients reported that their lawyer explained well, listened carefully, treated them with respect and spent enough time with them, and rated their lawyer as 4-5 (scale 0-5, 5=best lawyer).Sixty-nine (69/193, 35.7%) clients had complete data on health outcomes at the BASELINE and FOLLOW-UP periods to allow a paired analysis (Table).Days with poor physical/mental health in the past month, as well as in feelings of stress and worry in the past 2 weeks improved significantly. Self-reported overall health and days with no usual activities due to poor physical or mental health in the past month also improved, albeit not significantly. Missed appointments reduced significantly. There were also reductions, albeit not significant, in emergency departme

Replicating this Innovation: According to data from the National Center for Medical Legal Partnerships, MLPs have expanded across the nation, with programs in 450 health centers and hospitals, which has increased by over 100 locations from 2019.

Author(s):

Marc Scanlon, JD, Executive Direct, Salud Family Health Centers

CP32 - The Role of Community Health Centers in Removing Barriers for Latinx Patients to Mobilize for Health Equity During the Pandemic

Poster Type: Innovation

Category: Patient and Community Engagement

Issue or Challenge: Latinx communities are continuously among the least civically engaged communities throughout the U.S.. Limited economic opportunity and exclusion of low-income residents of color in decision-making exacerbate inequity in these neighborhoods, resulting in the growth of health and social disparities. AltaMed believes that Civic engagement is the vehicle through which working-class residents of color can be partners in changing the conditions that create health disparities in our communities. The COVID-19 pandemic brought additional challenges to sustaining civic engagement among hard-to-reach communities and simultaneously increased the need for them to be equitably represented in mobilization efforts (Montiel et al., 2020).

Description of Innovation: In January 2021, amidst the pandemic, AltaMed launched the Community Organizing Institute (COI) in an effort to build community power and tackle the lack of civic engagement amongst the populations that we serve. AltaMed believes that in order to truly address health disparities, the community must be at the center of all initiatives and be valued as partners at every step of design and implementation. This project leveraged popular education (Friere, 1996) and community participatory action strategies (Wallerstein & Duran, 2006) to engage patients in the co-development of a health equity agenda, advocacy planning, and development of community roundtables to express and address their concerns during the COVID-19 pandemic. In the summer of 2020, AltaMed surveyed a group of patients to assess their experiences and priorities during the COVID-19 pandemic. Patients were subsequently invited to discuss the results of the assessment and provide input on the design of a community education series. To further build capacity amongst patients and community members, AltaMed also launched the Advocacy and Leadership Academy(ALA) which was a 5-week curriculum designed to train participants in skills related to local, state and federal advocacy. In response to the engagement in these 2 opportunities, we launched the Community Organizing Institute(COI) with the intention of forming a community organizing group to mobilize around policy, systems, and environmental change campaigns to advance health equity during the COVID-19 pandemic. The COI serves as an opportunity for continued engagement of community members, patients and ALA graduates in direct advocacy.

Impact or Result: 35 residents improved their capacity to advocate locally and engage in long-term policy, systems, and environmental change. AltaMed improved its capacity to partner with community members and patients on community-led solutions to social determinants of health. AltaMed built infrastructure of a Community Organizing Institute composed of the Academy graduates and other community members.

Replicating this Innovation: Create concrete opportunities for patients to engage with and within the health system to advance health equity. AltaMed has a training curriculum for its advocacy and leadership academy. Launching a Develop a process for patient-led agenda-setting around priority issues. Invest time in preparing patients to improve their readiness to engage, and provide a dedicated staff member whose role is to sustain this engagement.

Author(s):

Noemi Mendez, Community Health Impact Project Coordinator, AltaMed Health Services Corporation
Corina Martinez, MS, Community Health Impact Manager, AltaMed Health Services Corporation

CP33 - COVID-19 Vaccine Confidence Among Federally Qualified Health Center (FQHC) Employees

Poster Type: Research

Track/Topic: Public Health Crises;Workforce

Research Objectives: The objectives of the cross-sectional online survey are to (1) understand what influences COVID-19 vaccine hesitancy amongst FQHC employees, (2) explore associations between vaccine hesitancy, demographic variables, and patient-facing employment; and (3) improve COVID-19 vaccine confidence among FQHC employees.

Research Study Design/Methods: Using self-reported data from a cross-sectional online survey, 462 FQHC employees completed questions on demographics, FQHC employment, COVID-19 vaccine hesitancy, and vaccine hesitancy influence(s). COVID-19 vaccine hesitancy was defined as answering, "No," or "Unsure," on willingness to be vaccinated. COVID-19 vaccine confidence was defined as willingness to receive the COVID-19 vaccine or already being vaccinated. Descriptive statistics and a contingency analysis using Fisher's Exact Test and unadjusted Odds Ratios were used to determine the association between COVID-19 vaccine hesitancy and gender, age, race, educational attainment, or being employed in a patient-facing role.

Research Principal Findings and Quantitative/Qualitative Results: Female employees were more likely to be vaccine hesitant than males [OR=3.09; 95% CI: 1.75-5.66, p35-years old were more likely to be vaccine hesitant than employees =35-years old [OR=2.89; 95% CI: 1.91-4.40, p0.0001]. Blacks were more likely to be vaccine hesitant than Whites [OR=3.04; 95% CI: 1.70-5.60, p<0.0001]. Non-patient-facing employees were more likely to be vaccine hesitant than patient-facing employees [OR=1.74; 95% CI: 1.15-2.64, p=0.008]. Educational level had the largest effect size.

Research Conclusions on Impact on Health Centers: These findings highlight the importance of sociodemographic factors in understanding COVID-19 vaccine hesitancy and confidence among FQHC employees. The factor that seemed to be most important was education. Employees with less formal education were more likely to be vaccine hesitant. Since FQHC employees serve our nation's most vulnerable and underserved populations, they have the potential to influence FQHC patients' knowledge and attitudes around COVID-19 vaccine acceptance. FQHC employees along with FQHC patients, should be the focus of greater research and education efforts.

Authors:

Daniel Parras, MPH, Research Data Analyst, Health Choice Network

Katherine Chung-Bridges, MD, MPH, Director of Research, Health Choice Network

Shelly Sital, MPH, Project Director, Testing and Surveillance, AllianceChicago

Stephanie Smith, BHSA, Manager, Clinical Quality, Health Choice Network

Jena Wallander Gemkow, MPH, BSN, RN, Clinical Research Manager, AllianceChicago

Andrew Hamilton, RN, BSN, MS, Chief Informatics Officer, AllianceChicago

Timothy Long, MD, Chief Clinical Officer, Health Choice Network

CP34 - Adapting Dental Care Facilities to SARS-CoV-2: Reports from National Dental Practice-Based Research Network Practitioners

Poster Type: Research

Track/Topic: Public Health Crises

Research Objectives: The SARS-CoV-2 pandemic prompted dental practitioners to reduce potential risks of virus transmission at dental facilities. This study identified approaches used by National Dental Practice-Based Research Network (Network) practitioners to reduce the risks of SARS-CoV-2 transmission at dental facilities, information sources, and comfort levels with infection control and their costs.

Research Study Design/Methods: We invited participation from 5,450 active U.S. dentists, hygienists, and therapists who were enrolled in the Network on January 4, 2021. The protocol was approved by the Central and Regional Node IRBs. Practitioners were recruited via email and telephone from January 1 to February 14, 2021. We collected data SARS-CoV-2-related facility modification, patient flow and screening changes, procedure modification and PPE use, and information sources. We use chi-square and t-tests to compare results by practice setting, including federal and public health, and practice type. Regression and forest-plot analyses of practice and practitioner characteristics will be reported.

Research Principal Findings and Quantitative/Qualitative Results: 1529 respondents met study inclusion criteria. Respondents were representative of the Network members. We found most (75%-98%) practices reduced exposed surfaces and enhance social distancing; 40% closed wait areas. High-velocity evacuators were the most common change to operatories. Staff spent a median extra 40 minutes/day disinfecting dental office space. Overall, only 14% were concerned about providing care safety while 27% of community health/publicly supported dentists had similar concerns. Overall, 50% of practitioners (44% of publicly supported dentists) reported being somewhat to not-at-all confident their practice could maintain current patient volume, revenues, and SARS-CoV-2-related costs over the next 24 months.

Research Conclusions on Impact on Health Centers: National Dental PBRN practitioners, including dentists from community-based and publicly supported settings, reported multiple changes to dental office facilities, equipment, and disinfectant practices aimed at reducing the risks of SARS-CoV-2 virus transmission. Most practitioners had low levels of concern that they could safely care for patients, but community and publicly funded dentists had the highest levels of concern about safety among dentists in different settings. Overall, there was a notable lack of confidence in the financial sustainability of clinical practice over the next 2 years. Data cleaning and regression modeling are underway and will be reported at the presentation.

Authors:

Jeffrey Fellows, Senior Investigator, Kaiser Permanente Center for Health Research

CP35 - Team-Based Home Blood Pressure Monitoring to Improve Hypertension Control Among Uninsured Patients

Poster Type: Innovation

Primary Funding Source: American Medical Association, American Health Association, West Side United, Centene Corporation, NACHC & CDC Million Hearts® Innovation Award

Category: Quality of Care and Quality Improvement

Issue or Challenge: Esperanza Health Centers is a FQHC that serves a primarily Latinx population on Chicago's southwest side. In 2018, Esperanza achieved a hypertension control of 80%, and we were selected as one of the Million Hearts® Hypertension Control Champions in 2019. However, amidst the COVID-19 pandemic, our hypertension control dropped to 58% in 2020. With the shift to telemedicine, we found an increase in the number of visits with no documented BP measurement and discovered uninsured patients were less likely to own a blood pressure monitor compared to insured patients.

Description of Innovation: We distributed blood pressure devices to uninsured and under-insured patients with hypertension through phone outreach and at our COVID19 vaccination sites, provided home blood pressure monitoring education and support to patients over the phone, and ensured patients followed-up appointments with their primary care provider. Strong evidence shows that home blood pressure monitoring plus clinical support helps people with hypertension lower their blood pressure. Home blood pressure monitoring enables providers to better manage hypertension and helps patients take an active role in the process. Furthermore, home blood pressure monitoring enhances the telehealth experience for patients and care teams. We utilized data from our EHR to help identify patients eligible for BP cuffs and leveraged Esperanza's existing team-based care model. At Esperanza, care teams consist of a provider, a medical assistant, and a care coordinator who work closely together during the visit and in-between visits to provide high-quality care for patients. Every care team member plays a role in improving hypertension control. We developed a workflow that aligns with the care coordinators' existing role in providing education, connecting patients to internal and community resources, and providing population health outreach to address patient care gaps.

Impact or Result: As of 04/08/2021, we sent BP monitors to 471 uninsured and underinsured patients with hypertension. Prior to our program, 17% of uninsured patients with hypertension had a BP monitor order. Now, 28% of uninsured patients with hypertension have a BP monitor order, which is an 11% increase. Of the patients in our program, 56% have a BP reading entered into their chart during the program measurement period. Since the program is currently underway, patients without a BP reading this year will have additional calls with their care coordinators and the majority have upcoming appointments with their primary care providers. We will continue to monitor the number of BP monitors sent to patients, the percent of patients with a BP reading in their chart, and the hypertension control rate for those patients. Additionally, we will monitor the number of care coordinator calls and telemedicine appointments with a BP reading entered.

Replicating this Innovation: For community health centers interested in adopting this model, we recommend establishing partnerships with organizations with technical expertise (e.g., AMA, AHA) for SMBP training and support, forging relationships with existing community-based organizations and coalitions, and collaborating with different departments within your organization to review baseline data on hypertension patients, create a workflow that includes EHR documentation, incorporate current roles involved with hypertension improvement efforts, and identify measures to track progress of new processes.

Author(s):

Sonia Ayala, MA, LCSW, Manager of Health Equity, Esperanza Health Centers

Rachel Cheung, Practice Transformation Associate, Esperanza Health Centers

Andrew Van Wieren, MD, Medical Director, Esperanza Health Centers

Carrie Kindleberger, APN, FNP-BC, Family Medicine Lead Provider, Esperanza Health Centers

Ted Hufstader, MPH, Director of Quality and Practice Transformation, Esperanza Health Centers
Paola Seguil, MS, RD, LDN, Quality Manager, Esperanza Health Centers

CP36 - ACCESS Westside Healthy Start: Impact of Integrated Support Systems for Maternal Child Health

Poster Type: Innovation

Primary Funding Source: Health Resources and Services Administration Maternal Child Health Bureau

Category: Quality of Care and Quality Improvement

Issue or Challenge: Infant mortality (IM) serves as a proxy for community health and access to quality health services and while the U.S. 2018 infant mortality rate (IMR) was 5.7 deaths per 1,000 live births , significant disparities persist by geography, race, and ethnicity. Chicago is no exception. The average IMR (2013-2017) for Chicago is 6.6 deaths per 1,000 live births while on the westside of Chicago in the community areas of Austin, East Garfield Park, West Garfield Park, North Lawndale, and Humboldt Park the average IMR is 11 deaths per 1,000 live births, 1.67 times the Chicago rate.

Description of Innovation: Access Community Health Network (ACCESS) provides community-based health care and serves the target community areas of Austin, East Garfield Park, West Garfield Park, North Lawndale, and Humboldt Park. To reduce infant health disparities, ACCESS obtained federal funding to establish its Westside Healthy Start (WHS) program and partnered with another local FQHC to provide targeted family-centered and comprehensive case management services utilizing a life course approach from preconception to 18 months postpartum. To seamlessly provide services, WHS instituted a care team approach to support participants and coordinate services. WHS' primary focus is to promote adequate prenatal care and provide education and resources on topics such as safe sleep to reduce chances of premature or low birth weight babies, Sudden Infant Death Syndrome (SIDS) or other leading causes of infant mortality. To meet participant needs, WHS devotes efforts to community education to drive collective impact and developing and maintaining strong community relationships. Through this innovative infrastructure, case managers connect participants with resources and education at the health center, telephonically, and at home to ensure pregnancy and overall health and wellness goals are met. This approach helped to reduce health disparities affecting mothers and babies on Chicago's West side.

Impact or Result: The average IMR (2013-2017) on the Westside of Chicago in the community areas of Austin, East Garfield Park, West Garfield Park, North Lawndale, and Humboldt Park is 11 deaths per 1,000 live births while for WHS participants, the average (2014-2019) IMR is 6.6 deaths per 1,000 live births. Several factors contribute to the reduced IMR. ACCESS WHS' safe sleep education and community partnerships connect participants with safe sleep resources (Ex: Pack 'N Play™) and contributes to an increase in participants reporting safe sleeping practices from 72% in 2017 to 80% in 2020. Breastfeeding can also reduce the incidence of SIDS. Therefore, WHS focuses on initiation and duration. WHS' partner LCHC reported increased rates from 58% in 2017 to 64% in 2020. While exchanging lessons learned, LCHC stated their success is due to a strong breastfeeding culture and specifically named the influence of midwives and breastfeeding educator on breastfeeding.

Replicating this Innovation: Replication of this model can be done by investing in the maternal and child health workforce including a non-clinical support system that can connect participants with social services and community resources. Keys to replications include (1) developing strong relationships with the community and organization, (2) utilizing a care team approach, (3) customizing workflow development, and (4) incorporating evaluation activities to monitor progress and program effectiveness.

Author(s):

Lindsay Zeman, Evaluation Specialist, Access Community Health Network

Timika Anderson-Reeves, Director of Maternal Child Health & Women's Health Community Integration, Access Community Health Network

Dara Gray Basley, Manager of Health Equity, Access Community Health Network

CP37 - Diabetes Care Program: A Nurse-Led, Team-Based Approach to Chronic Disease Management

Poster Type: Innovation

Category: Quality of Care and Quality Improvement

Issue or Challenge: Diabetes is a complex chronic illness that has significant medical, social, and financial impacts when the disease is not controlled. The percentage of poorly controlled diabetic patients at Community Health Care (CHC), a Federally Qualified Health Center, in April 2019 was 32%. This percentage included patients whose Hemoglobin A1c (HgbA1c) was greater than 9% or untested. Each patient with a poorly controlled A1c is at risk for serious complications. The problem needed to be addressed in an innovative way to improve patient outcomes, reduce total cost of care for these patients, and improve both the patient and provider experience.

Description of Innovation: The creation of the Diabetes Care Program (DCP) was an exciting initiative to improve patient engagement, disease management, and clinical outcomes for patients with uncontrolled diabetes. The development of a formalized DCP shifted diabetes management from a primarily individual provider and patient model, with limited provider access and time, to a team-based model led by nurses with a focus on patient education and engagement. The new care model consists of a nurse visit with the patient immediately before the provider visit and routine follow-up phone calls with the nurse and patient. The nurse uses motivational interviewing and patient education to engage patient in disease self-management with consideration of social determinants of health. Another component of the project was establishment of workflows to outreach to patients that needed diabetes care but had not had a diabetes visit in the last year or were overdue for follow-up based on their last visit. Clinical workflows include specific patient outreach and point of care diabetes management, regardless of initial reason for visit. These workflows help ensure patients' chronic disease needs are consistently considered, evaluated, and managed.

Impact or Result: The impact of the DCP was significant. Our baseline data revealed that 32% of diabetic patients had an uncontrolled or untested Hgb A1c. After 9 months of program utilization, the uncontrolled percentage decreased to 25.9%. There were 345 patients enrolled in the DCP and 83% percent of those patients showed improvement in their A1c scores during their enrollment in the program. Furthermore, 57% of those patients ended with a level less than 9%. The average A1c decreased from 11.5% to 8.9% in the enrolled patients. Additionally, the clinical care teams enjoyed this work which may have contributed to improvement in overall staff satisfaction survey results.

Replicating this Innovation: The DCP is a program that has an ability to easily be replicated at other organizations providing care to patients with diabetes. We were able to use existing staffing models with an RN on every care team to shift the schedules to accommodate the new workflows and RN patient support. The RN staff enjoyed this level of patient interaction. Additionally, the development of outreach and mechanisms to evaluate diabetes in patients regardless of the initial reason for the visit provided an opportunity to better manage chronic disease and provided an opportunity to truly function as a Patient Centered Medical Home.

Author(s):

Theresa Jennings, DNP, ARNP, FNP-c, Family Nurse Practitioner, Clinical Assistant Professor, Community Health Care, Inc; University of Iowa College of Nursing

Rebecca Hayes, MD, MEHP, CMO - Pediatric and Internal Medicine Physician, Community Health Care

CP38 - Interprofessional Student Teams Add Value to Patient Care While Learning Team Skills

Poster Type: Research

Track/Topic: Quality of Care and Quality Improvement;Workforce

Research Objectives: We tested the feasibility and impact of implementing the innovative Interprofessional Learning, Experience and Practice (ILEAP) model of student teams in a Federally Qualified Health Center (FQHC) to promote the uptake of preventive services by adult patients, while students applied and strengthened team-based collaborative skills in an authentic clinical setting.

Research Study Design/Methods: The ILEAP project partnered with the FQHC to place teams of 3-5 first-year students from multiple healthcare programs to provide screening, education, and care coordination one session weekly for 5-8 weeks. Student pairs interacted with patients before or after the primary care provider (PCP) visit. Students receive training in team skills and patient communication (motivational interviewing) and complete an online curriculum while onsite. Eligible patients were identified by student chart review and the clinical champion. Champions met with student teams twice per session. Aggregate counts of patient services were recorded; continuous assessment of student team skills performance was conducted.

Research Principal Findings and Quantitative/Qualitative Results: Over four years, ILEAP placed 34 teams totaling 144 students across multiple sites; 8 teams totaling 37 students were placed in one FQHC and provided patient services including screening and education for up-to-date preventive services and recommended referrals for other care. Teams impacted the acceptance of immunizations (pre-COVID) and use of the Fecal Immunochemical Test (FIT) for colon cancer screening. Education and referrals for dental care, breast and cervical cancer screening, diabetes-related eye exams, and other immunizations were the most common topics. Teams demonstrated significantly enhanced attitudes and team skills performance after clinic site experience compared to before.

Research Conclusions on Impact on Health Centers: Interprofessional student teams were incorporated into clinic flow and added value to patient care without excessive burden on site clinical personnel or resources. Initially, the FQHC was financially supported for its participation, but continued to participate and host student teams without remuneration. The impact on the site, in addition to the number of services provided by student teams, was the paradigm shift in the site's vision of how a student team could contribute to patient care and how the site could contribute to student learning of collaborative care skills.

Authors:

Catherine Demko, PhD, Associate Professor, Case Western Reserve University

Ellen Luebbers, MD, Assistant Professor, Case Western Reserve University

Cheryl Sarakauskas, RN, RDN, CDE, Wellness Coordinator, Neighborhood Family Practice

CP39 - Addressing Social Determinants of Health Through Mobile Medical Van in Miami-Dade County

Poster Type: Innovation

Category: Social Determinants of Health

Issue or Challenge: The purpose of the Mobile Medical Van (MMV) is to improve access to early, comprehensive primary care services among South Florida's most vulnerable populations by addressing social determinants of health (SDOH) including transportation, food insecurity, housing, insurance coverage and other barriers that contribute to health inequities. Though Miami-Dade County has nearly 20% of all individuals below the federal poverty line, people experiencing homelessness and those living in public housing have even greater needs. Community Health of South Florida's (CHI) MMV initiative was designed to serve these populations through comprehensive primary and behavioral health care and by addressing SDOH.

Description of Innovation: The mobile medical van (MMV) is the only comprehensive full-service mobile clinic in the area serving the population (public housing, early childcare centers and homeless encampments) through a lens of addressing social determinants of health through a care management model. The MMV provides full-service primary care and behavioral health services, an SDOH assessment integrating the PRAPARE Assessment tool, laboratory services, immunizations, cancer and STD screening, EKG, telehealth (to link with other providers), support with insurance, linkages to community resources and support with accessing public benefits. The van operates in close partnership with community organizations and the public housing authority. MMV patients become part of the CHI network and have access to all CHI support services, as appropriate, including referrals for ongoing care, comprehensive disease management and care reminders. Comprehensive evaluation of the MMV supports a deeper understanding of SDOH among this population and how addressing SDOH at the point-of-care can lead to improvement in core clinical measures. The MMV population is regularly assessed for SDOH, support follow-through and UDS clinical quality measures.

Impact or Result: We assessed results from the first eight months of MMV implementation, which took place at the height of COVID-19 cases in South Florida (July to February, 2021.) Overall, 178 people received care at MMV and were assessed for SDOH. In terms of SDOH, 48% of our patients indicated they had one or more barriers to care including transportation (21%), housing stability (19%) and food insecurity (15%). Over 49% of clients reported that if the MMV was not available, they would have gone to an urgent care or emergency department, and 25% said they would have remained sick and not received healthcare. In terms of clinical measures, data suggests that MMV clients have poorer diabetes control (48%) and cervical cancer screening (50%), but higher 1st trimester entry into prenatal care (100%), screening for depression (79%) and statin therapy for prevention of CVD (85%), compared to the 2030 HRSA target.

Replicating this Innovation: MMVs can be adapted by other Health Centers and clinical settings, provided they have community need and sufficient funding for staffing and sustainability. It is important to recognize the role of building trust within the communities and to use the skills of trained outreach workers to reinforce linkages within, and across, clinical and social service settings. MMVs can reach the vulnerable populations by delivering health services curbside in communities of need and addressing not just medical and behavioral health conditions but also SDOH at the community level.

Author(s):

Tony Amofah, MD, MBA, FACP, Chief Medical Officer, Community Health of South Florida, Inc.

Peter Wood, VP Planning and Government Affairs, Community Health of South Florida, Inc

Eunice Hines, MPH, CCHW, CHC, Director for Migrant Health & Outreach Services, Community Health of South Florida, Inc

Rachna Patel, OMS_IV, MPH candidate, Nova Southeastern University - KPCOM MPH program

Nicole Cook, PhD, MPA, Associate Professor, OCHIN

CP40 - Bite of HOPE

Poster Type: Innovation

Primary Funding Source: Novo Nordisk and Harris County

Category: Social Determinants of Health

Issue or Challenge: The Bite of HOPE culinary program is a upstream model designed to change the food environment in Houston. It is the first low cost culinary institute, accredited by the Texas Workforce Commission, focusing on integrating the medical and culinary resources in the community to change perceptions about food and change the way Houston eats. The goal with this program is to educate the different communities on the benefits of healthy eating, create next generation of healthy cooking chefs and food businesses, and integrate health care and eating in seamless transition.

Description of Innovation: HOPE Clinic believes that it can change the way Houston eats by empowering food stakeholders and community members with the knowledge food has over our health and bodies along with the power and responsibility business have with their patrons. HOPE Clinic's Bite of HOPE program has the mission to improve communities through knowledge of healthy food and healthy culinary practices. Since its conception, this program has:1) Filled an existing gap in the elementary school curriculum which does not incorporate health food education. The program pioneered a food and nutrition afterschool education program with Alief ISD to empower children to make healthy choices throughout their lives, foster food literacy and teach culinary skills. 2) worked closely with over 180 school counselors and nurses providing them nutrition education and cooking demonstrations with the goal of providing them with a more comprehensive and complex approach to nutrition education and change taking into account the psychological and social dimensions, which are more appropriate to address the growing prevalence of diet-related chronic diseases in Houston.3) During COVID-19, Bite of HOPE established a Youtube channel (A Bite of HOPE) as a platform for home bound families to share and discover healthy recipes and delivered food supplies needed to prepare the recipes. It also partnered with United Health care to reach home bound Seniors.4) Implemented a successful small food business leadership program with to transform the way Houston eats, buy helping restaurant owners become healthy food outlets and champions of healthy practices.

Impact or Result: Bite of HOPE is working on a evaluation strategy that would measure changes in the menu of small business, as well as changes in eating practices of Alief ISD families. The program has been successful in helping recruiting small food business to embrace healthy menu changes.

Replicating this Innovation: Bite of HOPE is currently being partially replicated in Philadelphia.

Author(s):

Andrea Caracostis, MD, MPH, CEO, Asian American Health Coalition dba HOPE Clinic

CP41 - Transforming Oral Health Care Through the Use of Teledentistry Before, During, and After COVID-19: FQHCs' Perspective

Poster Type: Research

Track/Topic: Technological Solutions and Tools to Improve Care and Population Health Management

Research Objectives: The objectives of this research were to identify and explain trends in how safety net clinics used teledentistry during the first year of the COVID-19 pandemic, to triage care for patients with dental emergencies, deliver preventive services, and manage progressive disease using minimally invasive dentistry.

Research Study Design/Methods: We conducted a community engaged mixed methods study with Health Choice Network (HCN). We extracted data including procedures, encounters, and patient information from the dental records of patients at twenty clinics ($n=488,024$). We conducted semi-structured individual interviews with representatives from these clinics ($n=21$). We analyzed interview transcripts, and member checked findings with community partners. Qualitative results guided the quantitative analysis, which we conducted by examining patterns and factors associated with teledentistry utilization. We then compared the results of the statistical analysis with those of the qualitative analysis to identify and seek to explain areas of concordance and discordance.

Research Principal Findings and Quantitative/Qualitative Results: Health centers that had used teledentistry before the pandemic; that had strong medical-dental integration in which telehealth was established on the medical side; whose states provided clear and early assurance of reimbursement; and that approached teledentistry as a “team effort” requiring ongoing training and commitment were more successful in utilizing teledentistry as a resource for serving dental patients during the pandemic. Conversely, health centers whose staff were skeptical of telehealth; who experienced reopening pressures from various stakeholders; or whose patient population faced intervening social determinants of health were less successful in optimizing teledentistry to address patients’ dental needs.

Research Conclusions on Impact on Health Centers: Teledentistry was an important resource that many safety net clinics used during the first year of the pandemic to triage patients with suspected dental emergencies, deliver preventive services, and manage progressive disease using minimally invasive techniques. Contextual factors including policy climate, staffing characteristics, and confidence in the modality influenced clinics’ introduction and sustainment of teledental services. Acknowledging the likelihood of future pandemics, teledentistry preparedness is an essential activity in pandemic preparedness to manage population-level disease, maintain revenue, and reserve in-person resources for emergency or urgent dental needs.

Authors:

Sarah Raskin, Consultant/ Assistant Professor, Virginia Commonwealth University

Madhuli Samtani-Thakkar, Biostatistician, Analytics and Evaluation, CareQuest Institute for Oral Health

Vuong Diep, Health Science Specialist, Analytics and Evaluation, CareQuest Institute for Oral Health

Farren Hurwitz, Business Development Manager, Health Choice Network

Julie Frantsve-Hawley, Director, Analytics and Evaluation, CareQuest Institute for Oral Health

Katherine Chung-Bridges, MD, MPH, Director of Research, Health Choice Network

Eric Tranby, Data and Impact Manager, Analytics and Evaluation, CareQuest Institute for Oral Health

Deborah George, Clinician, Jessie Trice Community Health Center Inc

Michelle Fundora, BHSA, CPHRM, Operations Manager, Health Choice Network

Margarita Ollet, MBA, BSN, RN, Executive Vice President and COO, Health Choice Network

CP42 - Research Ready: Improving Clinic-Based Research by Engaging Clinic Support Staff

Poster Type: Innovation

Primary Funding Source: Patient Centered Outcomes Research Institute

Category: Workforce

Issue or Challenge: Through our experience implementing research studies in Community Health Centers (CHCs) and other outpatient settings, the Louisiana Public Health Institute (LPHI) recognized that the role of clinic support staff is often overlooked. We found that when these staff are not comfortable with research, it hinders the success of studies and leads to poor experiences for patients, staff, and researchers. As more research is being conducted in clinical settings, engaging and training support staff members as champions for research will help equitably engage participants in non-traditional study sites, such as CHCs.

Description of Innovation: The project team designed, implemented, and evaluated Research Ready, a training to improve clinic staff capacity to partner in research. The training was developed to inform clinic staff, such as medical assistants and nurses, about basic research principles and considerations for supporting the implementation of research in a clinical setting. Research Ready is available in three formats: e-learning, facilitated session, and self-guided workbook. Research Ready was informed by interviews conducted with clinic support staff and researchers who had implemented studies in outpatient settings. Clinic staff from a variety of settings were interviewed, including Federally Qualified Health Centers (FQHCs), private healthcare systems, and academic medical centers. To date the training has been implemented and evaluated at over a dozen sites, including six FQHCs.

Impact or Result: Survey results showed that participants thought the Research Ready training was easy to understand and increased their knowledge about research. Results also showed that participants felt the information from the training was applicable to their jobs and helped them feel more comfortable talking with their patients about research.

Replicating this Innovation: Research Ready materials are available for free on LPHI's website. Any organization who is interested can access and use the resources to implement the training. The e-learning module is a self-study option that can be integrated into an organization's learning management system.

Author(s):

Daniele Farris, Senior Program Manager, Louisiana Public Health Institute

Margaret Sanders, Clinic Engagement Manager, Louisiana Public Health Institute

CP43 - Care Transformation: Care Team Roles and Realignment

Poster Type: Innovation

Category: Workforce

Issue or Challenge: Community Health Care is working to transition to value-based care and alternative payment models. Care team transformation and the reevaluation of staff roles and responsibilities is a critical part of this transition. In addition, provider and staff administrative and clerical tasks are a large contributor to burnout, leading to lower job satisfaction and engagement. CHC established a centralized team for medication, referral, diagnostic and document management that focused on medical assistants working to the top of their license. Many administrative and clerical tasks were shifted from patient-facing staff members to this centralized team, increasing staff satisfaction while improving patient care.

Description of Innovation: A Patient Access Center (PAC) was developed to address medication management (medication refills and prior authorizations), referrals (tracking and closure), diagnostics (prior authorizations, scheduling and tracking), chart updates and document management. These tasks were all originally part of each care team members' responsibilities, which led to multiple workflows and inconsistencies as patient facing staff were interrupted often during the day. PAC shifted this work to a centralized team of MA experts without patient facing responsibilities. Medication refills are now automatically routed to the team who follows an algorithm to refill medications or reassign back to the provider when indicated. Referrals ordered as part of a visit are automatically routed to the PAC team for processing and tracking to completion. Similarly, diagnostics are automatically routed to the team for tracking and any necessary prior authorizations. Patient charts are updated by PAC team members via a validated algorithm to ensure updated chronic problem lists, medication lists, immunization records, as well as medical/surgical histories. Lastly, PAC team members process and scan documents into patient charts as they arrive, so they are available to the care teams when needed.

Impact or Result: Medication Management: An average of 2,500 medications are refilled per month by the PAC team which is ~46% of all refills. This has decreased each providers' after-hour work time 4-6 hours per week. Referrals: The PAC team processes ~4,500 referrals per quarter and tracks these for completion. Diagnostics: The PAC team processes ~3,500 diagnostics per quarter and ensures prior authorization completion and timely processes. Chart Updates: PAC team members follow an algorithm to update patient charts for all consultant referral notes. This improves patient safety with more accurate charts and increases UDS measure documentation compliance. Soon, ER and hospital notes will also be part of this algorithm. Document management: The PAC team scans ~20,000 documents per month into charts. Overall: The average number of items in each MA inbox decreased from 21 in August 2020 to 8 in December 2020. Provider engagement increased 7% and nursing staff engagement increased 10%.

Replicating this Innovation: We suggest approaching a transition like this as a partnership between leadership and key stakeholders. We formally documented all care team members' tasks in order to determine which tasks should remain with the care team and which could be transitioned to the centralized team. We then did multiple time studies to determine the expected amount of work produced per centralized PAC team member (number of completed medication refills/hour for example). We then prioritized the parts of the PAC team and transitioned one aspect at a time, transferring 2-3 FTEs every few months to the centralized team.

Author(s):

Rebecca Hayes, MD, MEHP, CMO - Pediatric and Internal Medicine Physician, Community Health Care
Theresa Jennings, DNP, ARNP, FNP-c, Family Nurse Practitioner, Clinical Assistant Professor, Community Health Care, Inc; University of Iowa College of Nursing

CP44 - A Multi-Network, Nationwide Survey of EHR Satisfaction in CHC Users

Poster Type: Innovation

Category: Workforce

Issue or Challenge: The Arch Collaborative is an initiative by KLAS, a healthcare information technology (IT) research company, to gather insights on electronic health record (EHR) satisfaction through a nationwide survey of providers. Until now, the survey has focused on academic and private medical centers. AllianceChicago, a health center controlled network (HCCN), partnered with six other HCCNs to distribute the survey nationwide to gain insight into CHC EHR user satisfaction. In total, 126 of the 148 invited health centers used the survey and received 3,517 responses that will inform intervention strategies to improve EHR user satisfaction and address provider burden.

Description of Innovation: The Arch Collaborative survey has provided KLAS and medical institutions with a wealth of knowledge on EHR satisfaction. Because the survey has been given to providers who use a variety of EHR systems in academic and private medical centers, KLAS has distilled the responses into common elements that are associated with EHR satisfaction regardless of software brand. Before now, this survey had not been deployed to CHC providers, and the user habits of the CHC community were unknown. Our project aimed to fill that gap by partnering with other HCCNs across the country to deploy the survey to our respective network of health centers with a result of 126C HCs using the survey for a total of 3,517 responses from their clinical staff. AllianceChicago and its six partner HCCNs now have a robust data set of EHR usage and satisfaction rates that focus specifically on the unique needs of CHC users. This data will be used to inform EHR satisfaction interventions specifically for CHC users, to fulfil the HCCN grant goal of optimizing the provider experience and promoting joy in work while reducing provider burnout.

Impact or Result: This project was the result of a collaboration between seven HCCNs to reach a scale of CHCs larger than many other previous projects or initiatives. Concordantly, there is now a collaborative reaching 126 CHCs around the country focusing on the specific EHR needs of their providers. Each HCCN received data for their own network CHCs; the collaborative is currently in the process of compiling data from each of the seven HCCNs to analyze any larger trends that may be occurring across CHCs.

Replicating this Innovation: Each of the seven HCCNs involved in this project received their own data after the survey deployment; however, we are now discussing a plan to integrate all our data into a much larger data set to get nationwide insights on EHR use and satisfaction in CHCs. Eight additional HCCNs across the country expressed interested in joining the second iteration of our survey this coming year or are making plans to replicate the survey within their own network. All were open to and interested in exploring the idea of pooling the data set to contribute towards stronger CHC-to-CHC benchmarking.

Author(s):

Rebecca Silverman, MPH, Quality Improvement Advisor, AllianceChicago