Leadership and Innovation: Powering the Dynamics of Health Care Equity

Poster Presentation Guide

Hyatt Regency Chicago
August 28-30, 2022
Committee Meetings: August 26-27, 2022
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"NACHC is the only national organization dedicated solely to CHCs and the people we serve. Their leadership in preserving patient-centered boards, securing federal funding to care for the uninsured, and advocating for COVID-19 resources, are just a few of the reasons I am grateful for NACHC’s work."
- Dr. Simon Hambidge, CEO, Denver Health’s Community Health Services, NACHC MEMBER
Poster Presentations

Sunday, August 28, 2022, 5:00pm – 6:30pm • Monday, August 29, 2022, 12:30pm – 1:30pm
Riverside Exhibit Hall

The Community Health Institute (CHI) & EXPO is the ideal place to learn about current health center research activities and innovations. The 2022 Poster Presentations provide a unique opportunity to exchange ideas, problem-solve, and network with colleagues. Discover the results of innovative research initiatives and enjoy the opportunity to ask in-depth questions. To provide ample time for poster review, the 2022 Poster Presentations are scheduled for both Sunday and Monday during the CHI. Presenter attendance is required for Sunday, and strongly encouraged for Monday’s presentations.

2022 NACHC Poster Presentation Awards

There are 27 posters, including 7 A.T. Still University posters, to be presented during the 2022 poster session. YOU will choose the Best in Show posters! Vote for your favorite Research and Innovation posters on the mobile app, by clicking on Vote for the Best Posters. When judging poster presentations, please consider the following criteria: innovation of information, presentation of poster, relevance of topic, impact of findings, replicability of innovation, and value of information to other health centers.

All poster voting MUST be completed by 3:00pm on Monday, August 29.
When voting, refer to the conference program for instructions on downloading the app.
All 2022 CHI Poster Presentation winners will be announced during Tuesday’s General Session.

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

First Place: $250 AND a Complimentary Registration to the 2023 CHI & EXPO in San Diego!
Second Place: $150
Third Place: $100

A.T. Still University (ATSU)

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

The mission of the National Center for Community Health Research (NCCHR), a research alliance between the National Association of Community Health Centers (NACHC) and A.T. Still University, is to conduct quality research that considers the range of personal, social, economic, and environmental factors influencing health status; focus on underrepresented communities and vulnerable populations served by health centers; and address health equity by improving health, wellness, and well-being.
Poster Categories

The poster presentations are organized according to the following Community Health topics:

A.T. Still University

CP1  ATSU-MOSDOH Smiles for Veterans Program
CP2  Health Education Video Development: Improving Health Literacy in Afghan Refugees to Better Navigate the US Pharmacy System
CP3  COVID-19 Vaccine Hesitancy Amongst Adult Patients at Adelante Healthcare in Maricopa County, AZ
CP4  Misinformation Nation: Examining COVID-19 Vaccine Hesitancy and Misinformation Among Parents of Pediatric Patients
CP5  Exploring the Impact of EHR Optimization on Clinician Well-Being
CP6  Mindfulness-Based Interventions in Addressing Negative Health Outcomes Related to Adverse Childhood Experiences
CP7  Determining Average Height and Weight for the Mixteco-speaking Pediatric Population at the Community Healthcare Centers of the Central Coast

Demonstrating Value

CP8  Health Center 340B Program: Experiences of Patients on Injectable Diabetes Medication

Expanding Access to Care and Other Services

CP9  Spreading an SMBP monitoring program in an FQHC with multiple sites
CP10  Identifying Adult Patients with Undiagnosed Diabetes at FQHC Dental Sites

Improving Care for Special Populations

CP11  Addressing Special Populations During Periods of High COVID-19 Community Spread
CP12  Focus on elderly patients: Delivering a new service to patients using “old” ways in a new way
CP13  Development of a Gender-Affirming Model of Care to Improve Access, Engagement, and Health Outcomes for Gender-Diverse Populations

Patient and Community Engagement

CP14  Redesigning Patient Education on Contraception: Supporting Patient Choice with Engaging, Nonjudgemental Materials
CP15  FQHCs in the All of Us Research Program: Contributions, Lessons Learned, and Looking Ahead
CP16  Developing Best Practice Strategies for Retention from an Operational Perspective: A Use Case of an FQHC Partner of the AoURP
CP17  Resources for Precision Medicine: Genomics Return of Results Training for FQHC Staff in the All of Us Research Program
CP18  Factors Associated with Retention of Underrepresented in Biomedical Research Participants within the All of Us Research Program at an FQHC

Public Health Crises

CP19  Innovative 2D Barcoding Workaround Enhances Vaccination Best Practices in a Public Health Crisis
CP20  Southern Colorado Rural Recovery Network
CP21  Exploring Health Center Presence in COVID-19 Mortality Bright Spot Counties

Quality of Care and Quality Improvement

CP22  Quality Suggestions: An EMR nudge toward the Quadruple Aim
CP23  Utilizing the EPIC Electronic Health Record to Auto-Populate Obstetrics Quality Improvement Measures During Prenatal Visits

Social Determinants of Health

CP24  Exploring Relationships of Maternal Social Risk, Delayed Prenatal Care, and Infantile Weight
CP25  An Innovative Approach to Addressing Health-Related Social Needs

Technological Solutions and Tools to Improve Care and Population Health Management

CP26  Using Technology to Improve Health

Workforce

CP27  Eisner Health’s Journey Through Implementing Trauma-Informed Care
CP1

**ATSU-MOSDOH Smiles for Veterans Program**

**Poster Type:** Innovation  
**Category:** A.T. Still University  
**Issue or Challenge:** Funding was and continues to be a challenge for our organization. We had so many people, groups, and organizations donate to the project that we were able to make a great start, but the need is so great that we are currently having to put Veterans on a waiting list until we are able to secure more funding.

**Description of Innovation:** Missouri School of Dentistry and Oral Health (MOSDOH) Smiles for Veterans Project began in August 2017 at ATSU. Inspired by the university’s strong commitment to caring for the underserved, this project provides Veterans with much-needed oral healthcare in the form of free full or partial dentures and related services. Denture fit is assessed and perfected during multiple visits over a 2-month period. Teams of volunteer student dentists and licensed dental faculty provide services at each visit. To ensure continuity of care, each Veteran is assigned a team that provides complete denture services and follow-up care. This consistency reduces patient anxiety and allows trainees to practice developing strong relationships with patients.

Services are provided at the Dental Center, ~2 miles from downtown St. Louis. St. Louis has been designated a Dental Health Professional Shortage Area by the federal government, meaning dentist supply does not meet demand and residents struggle to access care. MOSDOH Smiles for Veterans collaborates with partners and volunteers to identify Veterans in need and provide care at a fraction of typical costs. MOSDOH and partners worked tirelessly to secure deep discounts on related services such as extractions, lab fees, and clinic rates, while also securing substantial volunteer time. The project setting, generous partners, and enthusiastic volunteers allow MVP to provide dentures at a cost to the program at just 10% of the typical rate (~$500/patient lab fees) and at no cost to Veterans.

**Impact or Result:** Thus far, we have treated more than 900 Veterans and delivered approximately 800 arches of complete or partial dentures. These Veterans, who would be unable to afford this care on their own, now have an increase in their dental health quality of life. The dental students also gained valuable clinical skills and learned the importance of the dental craft and how they can make a dramatic difference in a person’s life.

**Repetating this Innovation:** The best way to begin replicating this innovation is by indicating a population in need. Once recognizing the population in need, create avenues to obtain reduced fees for your cause from labs and other businesses involved in the fabrication of the product. Identify a staff and support base that will be able to volunteer and provide the services at little or no expense. Develop a way to identify and inform the population in need. Ensure you have the support you need, but most importantly have a commitment and passion toward your cause to make a difference in the lives of many.

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**Presenter(s):** Crystal Eschbach, Megan Stayton, Herbert Silva

CP2

**Health Education Video Development: Improving Health Literacy in Afghan Refugees to Better Navigate the US Pharmacy System**

**Poster Type:** Research  
**Category:** A.T. Still University  
**Research Objectives:** The US pharmacy system can be difficult to navigate for newly arrived refugees. The purpose of our project is to take a qualitative approach to developing an effective video intervention, for Dari-speaking Afghan refugees, on how to access and utilize pharmacy services at the HealthPoint community health center.

**Study Design/Methods:** Participants of interest included healthcare workers who have experience working with the Afghan refugee population. Participants were recruited via email or approached directly in the clinic to be interviewed; 21 one-on-one semi-structured interviews were conducted through phone, Zoom, or in-person. During interviews, participants were introduced to the concept of the educational video intervention and asked questions about their experience and expertise. Responses were recorded and analyzed by sub-investigators for trends in common suggestions, recurring insights, and perceived challenges, and then compiled into a centralized document to create the final outline for the educational video.

**Principal Findings and Quantitative/Qualitative Results:** With qualitative data collected from 21 key players of the healthcare team for refugee patients, common themes were extrapolated to produce topics for the development of an educational video. Pharmacy topics that emerged included describing the medication refill process, insurance coverage, safe medication use and discerning between types of medications, such as acute, chronic, and as needed. Amongst other topics unrelated to pharmacy, are topics distinguishing between emergent, primary, and preventative care. The development and implementation of the video should take into account these findings to create an educational tool that will effectively instruct Afghan refugees on navigating the US pharmacy system.
consideration both cultural and social factors, accommodating the wide spectrum of literacy and languages in the Afghan population.

Conclusions on Impact on Health Centers: We conclude that using a qualitative analysis of interview responses from healthcare workers at our CHC can yield helpful insights for creating a video intervention to assist Afghan refugees in navigating the US healthcare system. Through our findings, we outlined a sample video concept addressing pertinent pharmacy topics and created a list of additional health topics for future videos. We aim to present our work to HealthPoint to propose the creation of a culturally-tailored educational video intervention to be efficiently implemented in the clinical setting. This project can be adjusted for different patient populations to be replicated at other sites.

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CP3

COVID-19 Vaccine Hesitancy Amongst Adult Patients at Adelante Healthcare in Maricopa County, AZ

Poster Type: Research

Category: A.T. Still University and Public Health Crises

Research Objectives: The United States is currently experiencing significant COVID-19 vaccine hesitancy despite wide availability and accessibility to the vaccine. This study explores vaccine hesitancy and barriers to immunization among minority groups at Adelante Healthcare, a federally qualified health center (FQHC), in Maricopa County, Arizona.

Study Design/Methods: The study is based upon voluntary survey responses from patients at Adelante Healthcare. A multiple-choice survey was developed to (1) determine vaccination status and (2) explore reasons why patients have or have not received the vaccine. Surveys (n=3,150) were distributed to Family Medicine, Internal Medicine, and Obstetrics/Gynecology departments at seven Adelante Healthcare clinics within Maricopa County. Respondents were limited to patients who were eighteen years or older, elected to complete, and did or did not get vaccinated. Data was analyzed by breaking participants down into subgroups such as ethnicity, age, and gender.

Principal Findings and Quantitative/Qualitative Results: The observed survey response rate was 20.63% (650 of 3,150). Among respondents, 70.46% indicated they had received the COVID-19 vaccine and 29.54% indicated they were not vaccinated. This is consistent with current US vaccination rates. Principal findings included: (1) of unvaccinated respondents, 1 in 3 said nothing could change their mind about getting vaccinated for COVID-19; (2) both vaccinated and unvaccinated Hispanic/Latino men (9.85% of respondents) were more willing to get vaccinated for COVID-19 after a conversation with their physician; and (3) women of childbearing age (WCBA) (44.00% of respondents) were less likely to be vaccinated for COVID-19.

Conclusions on Impact on Health Centers: This study found there are a significant number of unvaccinated people who indicate no interventions could change their mind about receiving the COVID-19 vaccination. The data indicate certain subgroups are likely to respond to specific interventions (e.g., Hispanic/Latino men are more likely to get vaccinated after a conversation with their physician). Amongst WCBA, a notable source of vaccine hesitancy was concern about fertility. These findings will be presented to Adelante Healthcare and other FQHC providers in hopes of influencing vaccination rates. We hope this research will also help public health authorities make changes in their approach to improving vaccination rates.

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CP4

Misinformation Nation: Examining COVID-19 Vaccine Hesitancy and Misinformation Among Parents of Pediatric Patients

Poster Type: Research

Category: A.T. Still University and Public Health Crises

Research Objectives: We gathered data on the beliefs and concerns held by parents of pediatric patients, ages 5-17, regarding the COVID-19 vaccine and identified barriers to receiving the COVID-19 vaccine.

Study Design/Methods: The approach of this project was through descriptive survey data collection. The survey questions were developed by the student investigators. Student investigators administered paper surveys to parents of pediatric patients, between the ages of 5-17, during their appointments at El Rio Community Health Center located in Tucson, Arizona. Participants filled surveys out prior to or during their visits. Both qualitative and quantitative data were collected. Assistance was provided by biostatisticians from A.T. Still University, who used the statistical program R to analyze the data provided, while students used an encrypted excel spreadsheet.

Principal Findings and Quantitative/Qualitative Results: There were 74 surveys administered and 73 completed, with a 98.6% response rate. One survey was removed from analysis for incompleteness. Approximately 73.5% of the sample population identified as Hispanic. Of vaccinated parents, 46.5% had vaccinated their child; 14.1% were planning to vaccinate their child; and 9.9% were undecided on vaccinating their child. 35.1% had a high hesitancy score, 28.1% were moderately hesitant, and 36.8% had low hesitancy. Concerns were regarding side effects, safety, or believing their child was too young (25.7%); mistrust of the vaccine (14.3%); and believing more research is needed (14.3%).

Conclusions on Impact on Health Centers: Within our surveyed population, 63.2% showed a moderate to high level of vaccine hesitancy. Hesitancy toward the vaccine was mainly attributed to potential side effects, lack of long-term studies, and concerns about conflicting information available regarding the COVID-19 vaccine. Despite considerable hesitancy, 70.5% of parents were vaccinated and 60.6% of parents had either already vaccinated their child or were planning to vaccinate their child. The information collected will be used to create a brochure for healthcare providers that will address vaccine hesitancy among the pediatric population at El Rio.

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Presenter(s): Sara Jalil

CP5

Exploring the Impact of EHR Optimization on Clinician Well-Being

Poster Type: Research

Category: A.T. Still University

Research Objectives: Clinicians report factors related to use of the electronic health record (EHR) as significant contributors to stress and burnout, which in turn affects access to care, patient safety, and care quality. This project aims to measure the impact of an EHR transition and workflow redesign on clinician wellness.

Study Design/Methods: Clinicians from various disciplines that provide care within the El Rio Health Center complete the Mini-Z survey as part of an annual quality improvement process. The Mini-Z is a brief survey which assesses clinician wellness and explores factors that may contribute to burnout such as stress, work control, values alignment, teamwork, documentation, time pressure, and EHR use. A comparative analysis of clinician responses to the Mini-Z survey, before and after a large scale EHR transition and workflow redesign, will be performed to explore the impact of the interventions on clinician wellness.

Principal Findings and Quantitative/Qualitative Results: This project is currently in progress and data collection is ongoing. Analysis of clinician responses to the 2021 Mini-Z survey demonstrated high levels of stress and frustration related to the EHR. It is anticipated that clinician responses to the Mini-Z in 2022 will reflect decreased stress levels related to EHR use as a result of the EHR transition and workflow redesign. Results will be used to inform EHR optimization and help improve clinician retention and positively impact continuity of care and decrease healthcare costs.

Conclusions on Impact on Health Centers: Stress related to use of an EHR can have a negative impact on clinician well-being. This stress can contribute to burnout and significantly impact the ability of health centers to maintain a healthy workforce and assure access to care for patients. Interventions
to address EHR-related stress and frustration ideally include both technical solutions as well as redesigning workflows to fully engage the entire care team and maximize clinician time spent working at the top of their licensure. Although a wholesale EHR transition may not always be necessary or feasible, smaller scale workflow redesigns can also be of value.

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Presenter(s): Mark Schildt

CP6

Mindfulness-Based Interventions in Addressing Negative Health Outcomes Related to Adverse Childhood Experiences

Poster Type: Innovation

Primary Funding Source: State of California ACEs Grant 504, A.T. Still University

Category: A.T. Still University, Expanding Access to Care and Other Services, Quality of Care and Quality Improvement, Social Determinants of Health, and Technological Solutions and Tools to Improve Care and Population Health Management

Issue or Challenge: Developing a workflow to incorporate the mindfulness videos into the patient visit relied heavily on the clinic’s existing adverse childhood experience (ACE) screening practices. We learned that there was a high rate of variability between providers, pods, and clinics in terms of adherence to the San Ysidro Health (SYH) ACE screening protocol. Therefore, we had to first help put in place a consistent practice of screening patients for ACEs before the intervention could be incorporated into the workflow.

Description of Innovation: In conjunction with the statewide campaign, SYH has created an ACE Screening Taskforce and initiated an effort to document ACE scores for all patients. Providers offer high-scoring patients behavioral health referrals, but long wait times make a point-of-care intervention necessary. We began by conducting a statistical analysis of previously documented ACE scores and prevalence of depression, anxiety, obesity, hypertension, and DMI/II to establish a relationship between ACEs and health outcomes among adult patients at SYH. Next, a workflow was developed to provide patients with mindfulness videos during their clinic visit. The intervention aimed to bring techniques directly to patients that they could practice independently while waiting for mental health services. The workflow was introduced and optimized at one of SYH’s largest clinics. Patients who completed ACE screenings during their visit were shown one of four mindfulness videos and subsequently asked to complete a survey that included personal demographics, perspectives on ACEs and mental health, and feedback on the videos. Patients were also provided with an informational sheet including QR codes and URLs allowing them to continue to use the resource outside of the clinic, easily and free of cost.

Impact or Result: We demonstrated a significant association between high ACE scores (≥4) and anxiety (OR: 5.183), depression (OR: 4.524), obesity (OR: 1.375), hypertension (OR: 1.295), and DMI/II (OR: 1.273). Of those patients shown one of the mindfulness videos (n=45), those with high ACE scores were identified (n=5) to highlight the perspectives of those for whom our intervention is geared. We found that 89% of patients (100% of those with high ACE scores) agreed or strongly agreed that the video was good quality and easy to understand; 71% of patients (90% of those with high ACE scores) agreed or strongly agreed that these techniques would help them to manage or reduce their stress; and 71% of patients (100% of those with high ACE scores) agreed or strongly agreed that they plan to use these mindfulness techniques in the future.

Replicating this Innovation: The newly developed workflow can be easily translated to other CHCs with minor adjustments for clinic-specific practices and protocols. In the case that showing an introductory video in-office is not feasible, patients can be provided with the informational sheets which describe the effect of ACEs on health outcomes and contain QR codes and URLs to watch the videos at a later time.

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Presenter(s): Leah Grinshpun
**CP7**

**Determining Average Height and Weight for the Mixteco-Speaking Pediatric Population at the Community Healthcare Centers of the Central Coast**

**Poster Type:** Research

**Category:** A.T. Still University, Improving Care for Special Populations, and Quality of Care and Quality Improvement

**Research Objectives:** California is home to 165,000 indigenous Mexicans, including the Mixteco-speaking population of the Central Coast, for which limited health information is available. This quality improvement project aimed to determine the average height and weight of the Central Coast Mixteco-speaking population in an effort to provide more culturally appropriate care.

**Study Design/Methods:** Retrospective chart reviews are being performed through Community Healthcare Centers of the Central Coast (CHCCC). Mixteco-speaking patients are identified by chart notes. Patients who speak Spanish only, English only, or have conditions that affect height or weight are excluded. Statistical analysis of included patients will be performed to determine average height, average weight, and corresponding standard deviations for patients 0-17 years old. From the resulting data, an interactive web-based tool will be created that allows healthcare providers to compare patient information to determined averages. After the data collection period, investigators will present the findings and how to utilize the web-based tool to providers at the FQHC.

**Principal Findings and Quantitative/Qualitative Results:**
Data collection is ongoing; 923 patient charts have been reviewed; 786 patients were excluded due to not meeting language criteria or having a condition that affects height or weight; 137 Mixteco-speaking patients were identified, with recorded height and weight data from 761 appointments at various ages. Using statistical analysis, average height and corresponding standard deviations will be determined for females and males. Results will be compared to CDC data for average pediatric height and weight. Data collection ended on May 31, 2022 and will be analyzed by June 14, 2022.

**Conclusions on Impact on Health Centers:** CHCCC providers anecdotally report shorter height for the Mixteco-speaking population. As these patients are usually below the 5th percentile on CDC and WHO growth curves, it is difficult to determine if patients should be further evaluated, creating a barrier to culturally appropriate care. We hope our findings provide height and weight information for this community to depathologize their height, guide clinical decision making, and allocate resources appropriately. Findings may be generalizable to other Mixteco-speaking populations served by FQHCs. Furthermore, FQHCs can use similar methods to determine average height and weight to provide culturally appropriate care for unique patient populations.

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**Presenter(s):** Sophie Alfaro, Joy Muwanes, Bryant Tran

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**Demonstrating Value**

**CP8**

**Health Center 340B Program: Experiences of Patients on Injectable Diabetes Medication**

**Poster Type:** Research

**Primary Funding Source:** The Ohio State University College of Pharmacy Outreach and Engagement Mini Grant

**Category:** Demonstrating Value

**Research Objectives:** This study aims to understand the lived experiences of patients receiving high-cost injectable diabetes medication(s) through a 340B Prescription Cash Discount Program provided at a community health center (CHC).

**Study Design/Methods:** This qualitative study explored the lived experiences of participants enrolled in the 340B Prescription Cash Discount Program for injectable diabetes medications via semi-structured individual interviews.

Patients > 18 years of age who utilized the 340B Prescription Cash Discount Program to fill a prescription for an injectable diabetes medication at least twice within the study period were invited to participate if they have had a diagnosis of diabetes for > 1 year and were comfortable completing the interview in English. Ten participants were interviewed by trained personnel and thematic analysis of the transcribed interviews was completed to identify emerging themes.

**Principal Findings and Quantitative/Qualitative Results:**
Common themes mentioned by participants were as follows: perceived benefits of using the 340B Prescription Cash Discount Program for their injectable diabetes medication were that they received savings, making their prescriptions more affordable, and that the program contributed to improvements in their diabetes control. A consequence of being without the program was that their injectable diabetes medication was too expensive for them to be able to take the medication as prescribed, and they were pleased with contract pharmacy

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accessibility and having the choice to choose their pharmacy among a network of contract pharmacies.

Conclusions on Impact on Health Centers: The 340B program has recently received criticisms questioning whether the program accomplishes its original intentions to stretch scarce federal resources to reach and treat more vulnerable patients. Although most criticisms are related to non-grantee entities, CHCs, grantees, and their patients are caught in the crossfire and significantly impacted by the attacks on 340B. This study’s results provide further insight into the personal impact the 340B program has had on underserved patients receiving high-cost injectable diabetes medication(s). Findings highlight crucial strengths of the program to share with key stakeholders to provide support for the continuation of these services.

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Expanding Access to Care and Other Services

CP9
Spreading an SMBP Monitoring Program in an FQHC with Multiple Sites

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

Issue or Challenge: Challenges included the Covid-19 pandemic, hesitancy in adding tasks to existing staff, and lack of blood pressure monitors. The shift priorities for staff during the pandemic made it difficult to expand the self-measured blood pressure (SMBP) initiative to all sites. Hesitation stemmed from required SMBP documentation that was developed at the onset of the program. The program was originally a loaner program, and lack of monitors impeded its spread. The PIA and chief medical officer redesigned and simplified the documentation processes to make the SMBP program more accessible to clinicians, the teams, and their patients. Due to the pandemic, monitors are given to patients to keep, which equipped participants to manage their hypertension, but created a supply shortage. Through collaboration between healthcare team members (physicians, nurses, MAs, pharmacists) and the PIA allowed for staff buy-in, ensured patient-centered treatment, and presented outcomes to funders and to staff, ensuring continued grant funding and interest from other sites to spread the program further. The PIA and a flexible team design ensured that patients across all sites received quality SMBP while acknowledging and addressing staffing challenges unique to each location.

Impact or Result: Zufall began its SMBP program with one provider and a medical assistant at one site. As of February 2022, the SMBP program is being offered to patients at all 7 sites and over 40 staff members have received training. The spread was successful even in the midst of the COVID-19 pandemic and 327 patients have participated in the program over an 18-month period. Support by the PIA and implementation of flexible teams engendered provider and staff buy-in, ensured patient-centered treatment, and increased program access to patients with hypertension. Clinicians and patients have reported high satisfaction rates with the program. As a result, 80% of program participants improved their blood pressure. Average systolic blood pressure decreased by 11 mmHg and the average diastolic blood pressure decreased by 6 mmHg.

Replicating this Innovation: To best implement the spread of an SMBP program in other organizations, Zufall Health Center recommends creating a PIA position and approaching each site using a flexible team approach to address staff and workflow at the site if this is feasible within your workforce. The collaboration between healthcare team members (physicians, nurses, MAs, pharmacists) and the PIA allowed for staff training, site-specific workflows and consistent deliverables to be implemented, resulting in improved patient health outcomes.

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**CP10**

**Identifying Adult Patients with Undiagnosed Diabetes at FQHC Dental Sites**

**Poster Type:** Research

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

**Research Objectives:** There is a known connection between periodontal disease and diabetes, offering a unique opportunity to conduct screening in the dental setting. We implemented a research study to test this connection at five Health Choice Network (HCN) FQHCs. Hemoglobin A1c (HbA1C) testing and education were provided to dental patients.

**Study Design/Methods:** A high number of patients with undiagnosed diabetes and pre-diabetes were identified in the study. During their dental appointment, patient candidates were informed about the research study and were provided the option to consent to participate. A point of care HbA1C test was administered to all participants. Patients with an HbA1c of 5.7-6.4% (pre-diabetes) were offered the next available medical appointment. Patients with an HbA1c of 6.5-8.0% (diabetes) were offered a medical appointment within 3 days. Patients with an HbA1c of >8.0% (diabetes with hyperglycemia) were offered a same-day medical appointment.

**Principal Findings and Quantitative/Qualitative Results:** Between September 2021 and March 2022, 732 patients from 5 HCN FQHCs were consented and recruited into the research study: 160 (21.9%) of the 732 patients screened positive for pre-diabetes (114 patients), diabetes (38 patients), and diabetes with hyperglycemia (8 patients); 67.5% were females; 48.1% were Hispanic; 39.4% were Black; 10.6% were non-Hispanic White; 36.9% were unemployed; and 83.8% were ≥40 years old. All 160 patients that screened positive were referred to a primary care provider (PCP) and were offered a medical appointment (same day, within 3 days, or next available) depending on their HbA1c level.

**Conclusions on Impact on Health Centers:** FQHC dental sites serve the nation’s most vulnerable and underserved populations and provide an opportunity to diagnose diabetes and pre-diabetes. These findings highlight the importance of establishing chronic disease screenings in the dental setting and integrating care between dental and medical clinics at FQHCs (i.e., medical-dental integration). This study paved the way for many of the participating FQHC dental sites to continue offering chronic disease screenings in the dental setting, and to continue strengthening medical-dental integration. The medical-dental integration model could benefit FQHCs and patients by enhancing comprehensive care, improving patient outcomes, and reducing the total cost of patient care.

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**Presenter(s):** Daniel Parras

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**CP11**

**Addressing Special Populations During Periods of High COVID-19 Community Spread**

**Poster Type:** Innovation

**Primary Funding Source:** This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H80CS28353 and title Health Center Program for grant amount $1,839,625.00.

**Category:** Behavioral Health Services, Improving Care for Special Populations, and Public Health Crises

**Issue or Challenge:** Initially, we were challenged by figuring out how to ensure individuals had proper shelter while sick. We partnered with Catalyst Rescue Mission to ensure a seclusion shelter was in place. We also were challenged by implementing infection control protocols while also trying to provide clinical care. We were able to use our mobile health services to try, to the extent possible, to separate potentially ill patients from well patients. An additional challenge was faced when implementing telehealth. Not everyone or every condition is appropriate for telehealth. Therefore, we had developed a quadrant model to determine which patients would be seen in person vs. through telehealth. We were able to ensure those most at risk for serious morbidity or mortality were able to access services in person throughout the pandemic. Finally, disinformation related to testing, treatment, and vaccinations led to significant problems in connecting individuals to care. We worked with the local health department and hospital to conduct a public education campaign around vaccinations.

**Description of Innovation:** We identified the primary locations individuals in the target population were using as access points for basic needs, including the local emergency shelter, emergency department, street outreach initiatives, local substance use disorder treatment facilities, etc. We prioritized prevention, testing, and vaccination in those locations which served the greatest volume of individuals first, then tailored...
programming around their care. This included mobile clinic outreach, vaccination clinics, seclusion shelter outreach, and a hospital-at-home model which allowed us to monitor individuals after they were infected with COVID. We also developed a risk-based quadrant model which assisted in making determinations about who was appropriate for in-person versus telehealth care.

**Impact or Result:** The outcome of the innovation was the availability of testing, vaccination, and treatment, without ever having to step foot into a community health center. We were able to meet our patients where they were, provide care for them, and ensure they had access to health services to keep them safe during the height of the pandemic.

**Replicating this Innovation:** By developing relationships with other service providers, developing internal capacity, and ensuring everyone is on the same page about how to handle the patient throughput, another organization could replicate this innovation. Next, you must determine who needs to be involved and what training needs to take place. Finally, an implementation plan needs to be developed that includes key stakeholders and clear timelines to implementing best practices.

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**Presenter(s):** Eric Yazel, Misty Gilbert

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**CP12**

**Focus on Elderly Patients: Delivering a New Service to Patients Using “Old” Ways in a New Way**

**Poster Type:** Innovation

**Category:** Improving Care for Special Populations

**Issue or Challenge:** A number of challenges were addressed. First, in bringing on new members to the care team, it was critical that communication be seamless. Therefore, we established protocols for the CCS nurses to use, giving them clear direction about what types of issues they should alert our triage nurses about, which issues should be communicated to the primary care nurse, and which require a PCP’s involvement. These protocols were put in place to address specific concerns raised by the care team. Second, while low-income patients who are enrolled in Medicare and Medicaid do not experience a copay for chronic care management (CCM) services, Medicare-only enrollees do have a copay, which may be a burden for patients. In FQHCs, patients have access to sliding-fee scale to assist with copays when needed, therefore patient cost is not a limiting factor. A third significant challenge we have experienced is onboarding nurses who are external to our organization. Although we are contracting with these nurses as other licensed or certified professionals, they require credentialing and privileging, training, and technical setup in order to perform their role. This requires timely coordination with the external organization and our IT and human resources departments.

**Description of Innovation:** Nationally, FQHCs serve approximately 75,000 patients age 65 and older, significantly less than the number of pediatric and adult patients age 18-64 that are served. Given the size of this population, they may not have access to all of the services they are eligible to receive, like CCM. At Community Health Center, Inc. (CHCI), we recognized the value of CCM and assigned responsibility for implementing this service to our primary care nurses (PCNs). However, PCNs may choose to staff an in-house team of nurses dedicated to CCM, we decided to contract with an external organization to deliver this service. The external organization is staffed by nurses whose only role is CCM and they enroll patients, develop care plans, and then systematically contact patients each month. The CCM nurses use CHCI’s EHR to document all communication with the patient and to the patient’s care team. The CCS nurses identify themselves to patients as an extended part of the FQHC care team and focus on both chronic disease related and preventive care.

**Impact or Result:** We enrolled and retained over 1,000 patients in Medicare CCM during the first year. We are assessing patient satisfaction and utilization of care for these patients. While the contracted organization conducts their own satisfaction survey with positive results, we also engaged our patient satisfaction survey vendor to survey patients with at least five months experience with CCM. The results showed that 87% of patients rated their overall satisfaction with CCM as good or excellent. Further, over 90% of respondents reported “Yes” when asked whether their coordinator helped with needed services, listened carefully, explained things in a way that was easy to understand, among other items. We will be analyzing in-patient hospitalization rates as well as uptake with preventive services to assess program impact as these are both areas of focus for the CCM nurses.

**Replicating this Innovation:** It is rare that Medicare creates a new benefit such as Medicare Annual Wellness Visits (MAWVs) or CCM, but when it does it is clear they have determined it to be beneficial for patients and generally, to be at least budget neutral. We saw this as an opportunity to support our patients in achieving better health outcomes and we believe that all eligible Medicare patients will benefit from this service. However, we have found uptake by FQHCs to be low and we recommend that all eligible Medicare patients in FQHCs have access to this service. This not only will support the individual
patients and collect more data to bring back to the larger care teams working with these patients, but it also allows for better reimbursement and therefore visibility of the many team members and activities that contribute to the overall health and well-being of our chronically ill patients.

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**Presenter(s):** Tierney Giannotti and Margaret Flinter

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**CP13**

**Development of a Gender-Affirming Model of Care to Improve Access, Engagement, and Health Outcomes for Gender-Diverse Populations**

**Poster Type:** Innovation

**Category:** Improving Care for Special Populations

**Issue or Challenge:** Providers had various experiences and backgrounds in serving gender diverse populations. A pre-assessment was designed to learn more about understanding and knowledge. This assessment was used to develop education plans. Consistent with innovation theory, there were early adopters and late adopters. The early adopters became the champions and gathered quarterly to identify best practices and challenges. We also ran into challenges with capacity among health navigators due to the rapid growth in the patient population. We worked with staff to identify culturally competent providers in the community and created a resource guide. This extended the knowledge of affirming and inclusive resources across all staff.

**Description of Innovation:** Equitas Health, an FQHC Look-Alike, has developed a model of care to serve individuals who span the continuum of gender diversity. The gender-affirming model of care is uniquely transformative. Through the use of the principles and techniques centered in palliative care, motivational interviewing, health literacy and cultural humility, we have created a supportive framework for patients to achieve their goals around gender, while improving their overall health. Training for providers and all clinic staff include training on informed consent and shared decision making when designing individualized treatment plans and prescribing hormones. Our practitioners are able to diagnose gender dysphoria and support our patients throughout their process of identity affirmation. At our clinics, you do not need prior approval from a psychiatrist or therapist to start gender-affirming hormone therapy.

**Impact or Result:** Between July 2019–June 2020, 1,937 unique patients received gender-affirming care. Four percent of the population had diabetes with 33% controlled which was consistent with the general population. Nine percent had hypertension with 80% controlled in comparison to 55% of the general population. Four percent were HIV positive with 72% virally suppressed in comparison to 55% of Ohioans living with HIV. We have also improved access to care with 57% of new patients entering care in our newest facility, which opened in 2020, identifying as gender diverse. With 300% growth among the patient population, the organization has revised forms to be more consistent with collecting sexual and gender-diverse identities.

**Replicating this Innovation:** (1) Evaluate mission and values in serving gender-diverse communities; (2) Develop Patient Advisory Board; (3) Design implementation plan and strategic framework for program development and evaluation; (4) Identify and engage champions; (5) Use change management best practices to increase understanding and buy-in; (6) Develop professional development plans for the entire staff; (7) Revise and create policies and procedures for gender-affirming care; (8) Identify community partners and develop memorandums of agreement; and (9) Design EMR documentation (registration, pronouns, etc.) to support affirming care.

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**Presenter(s):** Teagan Vaughn, Mel Carroll
**Patient and Community Engagement**

**CP14**  
**Redesigning Patient Education on Contraception: Supporting Patient Choice with Engaging, Nonjudgemental Materials**  
**Poster Type:** Innovation  
**Category:** Patient and Community Engagement  
**Issue or Challenge:** We began this research just as the COVID-19 pandemic took hold in the United States. We quickly pivoted to remote research and facilitation for the rest of the project. While this posed logistical challenges, it gave us valuable insights into how these materials could be translated into a virtual setting. We made sure our materials could be easily accessed online and shared digitally. We also created our digital companion to the printed materials: a patient-friendly, mobile-responsive webpage that patients can access from anywhere. We also made sure that the printed materials we gave to healthcare providers came fully laminated for easy sanitizing and provided guides on how they could integrate our materials into their digital communications with patients.  
**Description of Innovation:** We created a suite of educational materials that help patients and providers have better conversations about birth control. The materials are explicitly designed around choice. As a patient, you have options when it comes to contraception and the right to make decisions based on your preferences. Our materials are not organized around efficacy; instead, they offer information about the priorities that matter most to patients, like potential benefits and side effects, in a friendly, fact-based tone of voice. Together, our materials illustrate birth control options, address myths and misconceptions, and empower patients to play an active role in the counseling experience. Materials include: welcome booklet that sets the tone for the healthcare experience and prepares patients for their appointments; decision-making wheel that facilitates conversations between staff and patients on their birth control options by quickly comparing methods on key topics: hormones, potential side-effects, potential benefits, potential bleeding changes, and effectiveness; series of birth control postcards that offer more information about specific methods; one-pagers that are easily printed on an office computer for patient take-home material or used virtually in telehealth settings; and mobile-friendly webpage that helps patients make informed choices by filtering birth control methods based on side effects, benefits, and bleeding changes and to learn more information on each individual method.  
**Impact or Result:** Our materials are actively used by our health center partners across the country.  
**Replicating this Innovation:** Human-centered design can seem like a daunting task for entities with limited time and capacity. Yet, using principles from this framework does not have to be a large lift. Periodically checking in with patients on what's working and what's not regarding the information they receive during their healthcare visits can go a long way to improving patient aids and materials. The design framework of preferences and using nonsubjective language can also be replicated in other reproductive health materials.  
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**CP15**  
**FQHCs in the All of Us Research Program: Contributions, Lessons Learned, and Looking Ahead**  
**Poster Type:** Innovation  
**Category:** Demonstrating Value and Patient and Community Engagement  
**Issue or Challenge:** By their very nature and mission, FQHCs demonstrate time and again their ability to identify and overcome challenges faced by their communities. In fact, the innovations described in this poster provide examples of this very process. For example, FQHCs regularly face challenges making healthcare accessible across cultures and languages; in beginning work with the All of Us Research Program (AoURP), it came naturally to these teams to work to break down language barriers for engagement and enrollment in the program. More recently, it goes without saying, that the COVID-19 pandemic was particularly challenging for FQHCs. The AoURP suspended in-person activities for several months as FQHC communities and staff were impacted by the pandemic. Given the FQHC participants’ preference for in-person interactions, teams needed to find ways to maintain a high-touch approach, but virtually. They were able to successfully do so through the use of the computer-assisted telephone interview (CATI) tool.  
**Description of Innovation:** FQHCs have implemented myriad strategies in operationalizing the All of Us Research Program locally, with an emphasis on approaches best suited to engage, enroll, and retain their patients who largely comprise communities historically underrepresented in biomedical research. Notable examples will be shared including:  
- FQHCs led efforts to ensure all program materials, including the All of Us portal website, were available in Spanish to best meet the needs of their patients. This focus on accessibility is a hallmark of FQHC participation in the AoURP.  
- FQHCs partnered with MITRE to instantiate a common set of data elements to collect from all participants. These data have provided the FQHCs with insights about their participants and a data-driven mechanism to compare...
strategies across the FQHCs and the consortium more broadly, ultimately evolving participant engagement and communications.

- At the peak of the COVID-19 pandemic, when in-person activities were paused, FQHCs leveraged new technology (computer-assisted-telephonic-interviewing) to engage virtually with participants, rebuilding enrollment and retention momentum.

- FQHCs have strengthened their capacity to support anticipated AoURP enhancements, including developing genomics training resources to prepare staff for participant interactions.

- FQHCs have documented innovations and lessons learned in an online archive available to all AoURP consortium members, enhancing collaboration and efficiency.

**Impact or Result:** Since their involvement in the program in 2016, FQHCs have enrolled nearly 10,000 participants, more than 90% of whom are considered underrepresented in biomedical research. The innovations described in this poster have been instrumental in continuing the momentum of engagement with these participants, also contributing to recent successes with retention. These contributions extend the opportunity of the program to their communities, making the AoURP database truly reflective of the country’s diversity. Ultimately, these efforts will contribute to research discoveries that benefit FQHC patients and their communities. Additionally, the FQHCs’ contributions demonstrate the power of local healthcare organizations at the national scale. FQHCs have the dedication, leadership, and wherewithal required to operationalize a national longitudinal research study. FQHCs will continue to be a key factor in helping the AoURP reach its goal of 1 million participants.

**Replicating this Innovation:** Many of the innovations pioneered by AoURP FQHCs can easily be replicated by other organizations within the consortium, and some already are. Artifacts from efforts such as Spanish translation and genomics trainings are readily available for integration by other entities. Also, as described above, FQHCs have contributed to an expansive lessons learned library, maintained by MITRE, that is available to the entire program’s consortium and could be generalized and publicized more broadly. Moreover, the model of convening FQHCs to develop solutions tailored to their needs holds promise for other research consortia involving health centers.

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¹MITRE

**Presenter(s):** Jessica Burke, Derek Inokuchi

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**CP16**

**Developing Best Practice Strategies for Retention from an Operational Perspective: A Use Case of an FQHC Partner of the AoURP**

**Poster Type:** Innovation

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

**Issue or Challenge:** Retention strategies were designed to address challenges experienced with participants of Cooperative Health *All of Us* (CH-AoU). Challenges faced included invalid phone numbers and addresses, low digital literacy and access, and time commitment requirements. When mailing birthday cards, a process was established to document (REDCap) all return envelopes as an invalid address. This informed staff to update participant information at the next contact. This process ensured birthday cards were not continuously mailed to the wrong address. Computer-assisted telephone interview (CATI) addressed the low digital literacy and access challenge because the participant only needed access to a telephone. There were no requirements to have internet or digital devices available when completing retention via CATI. CATI and the combination of retention and clinical appointments aided with the challenge of lack of time. Participants were able to complete all outstanding retention activities or select the desired activity of choice, then completed the remaining activity at a different time point.

**Description of Innovation:** There is no one certain universal strategy for retaining underrepresented in biomedical research (UBR) populations; therefore, it was necessary for CH-AoU to develop retention best practices that were unique to the organization and population served, but could potentially be adapted and replicated at other FQHCs. CH-AoU tested strategies pre-COVID and during COVID that were either adopted as best practices or abandoned. Birthday cards were mailed monthly as an approach to keep participants engaged while also building trust in the program and the organization. Retention surge was an “all hands on deck” strategy when there was a need for a rapid retention boost. Cross checking daily clinical appointment schedules at CH-AoU enrollment sites to determine if retention-eligible participants were scheduled for upcoming clinical appointments. The goal was to combine clinical appointments with outstanding retention activities for convenience and to reduce the time commitment required for retention. CATI was adopted as a remote retention strategy to address the digital divide. Participants were not required to have internet or digital devices in order to complete retention via phone call. The following strategies were abandoned due to high effort and low yield:

- Summer Retention Internship: CH-AoU hired two graduate students to work specifically on retention. They were trained and provided tools to retain participants at enrollment sites.

- Floating Retention: staff traveled on a rotational basis to selected non-enrollment sites in order to retain retention-eligible participants who had clinical appointments.
Post Cards: retention post cards were mailed to retention-eligible participants.

Impact or Result: The Retention Surge (August 2019) was a week-long event that was comprised of phone calls, text messages, assistance with resetting passwords/security questions, and Saturday retention. The surge added 100 retentions and was adopted to be used as needed. Pre-COVID and ongoing, 68% of participants who completed at least one retention activity were mailed a birthday card beginning in October 2019. During COVID and ongoing, cross checking daily clinical appointment schedules (began June 2021, at reactivation following AoURP in-person pause) enabled CH-AoU to complete retention activities in person at the clinic sites. In-person retention was combined with clinical appointments. The AoURP implemented CATI on August 31, 2021, which allowed for retention to be completed remotely via phone call. In-person retentions and CATI represented 19% and 81% of completed retentions respectively. The combination of adopted retention strategies as best practices facilitated CH-AoU retaining 55% of the participants.

Replicating this Innovation: FQHCs serve underserved populations with similar challenges as CH. To replicate the retention strategies, FQHCs would assess the most relevant retention challenges facing the patient population that is being served. The strategies would require adaptation to meet the needs and to be most relevant for the specific challenge. The key to developing best practices is to test, adapt, adopt, or abandon as necessary.

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Presenter(s): Beverly W. Holmes

CP17

Resources for Precision Medicine: Genomics Return of Results Training for FQHC Staff in the All of Us Research Program

Poster Type: Innovation

Category: Patient and Community Engagement

Issue or Challenge: As with any program developed in the past two years, a major challenge was finding ways to connect with colleagues and foster collaboration remotely. For MITRE, there is a particular challenge in trying to meet the unique needs of seven different FQHCs that each serve vastly different populations. We adapted to these challenges by closely collaborating with FQHC leadership to personalize vastly different populations. We adapted to these challenges by closely collaborating with FQHC leadership to personalize.

Description of Innovation: Our genomics innovation for FQHC staff was twofold: first, to provide a training in foundational genomics knowledge (Genomics 101) and second, to train FQHC representatives in facilitation skills and genomics resources so they train their own staff in genomics (Genomics Train the Facilitator). Genomics 101 was split into two learning sessions: “Basics” and “Conversations.” In “Basics,” FQHC facilitators presented four genomics topic areas so FQHC staff could learn to comfortably discuss these foundational genomics topics with AoU participants. Topics included: Inherited vs. Acquired Traits – DNA and Genes, Inheritance, and Precision Medicine. In “Conversations,” FQHC staff were presented with key information about four genomics topic areas (terminology, consent, privacy, and return of results) and were guided through genomics conversation roleplaying exercises. For Genomics Train the Facilitator, each FQHC selected representatives to be trained as genomics facilitators. In the first session, staff had the opportunity to go through a genomics learning session and develop facilitation skills. In the second session, staff had the opportunity to go through the practice as facilitators and demonstrate their facilitation skills. Following these sessions, staff were asked to host their own genomics training for their FQHC.

Impact or Result: There was a significant improvement between pre- and post-assessments showing that the “Basic” training resulted in increased knowledge of foundational genomics information. Evaluations of the “Conversations” training were positive with most participants stating they could apply these roleplays to their future work. In the Genomics Train the Facilitator sessions, participants became more comfortable facilitating their own genomics trainings and roleplays. Participants expressed that the training helped develop their facilitation and public-speaking skills. Following these sessions, participants from six of the seven FQHCs facilitated their own genomics training for their staff. Staff who participated in the local sessions expressed that they became confident in their ability to have a conversation about genomics with an AoU participant. As a result of these trainings, FQHC staff have the skillset to have conversations about genomics that meet the needs of participants in the All of Us Research Program as they receive reports about their DNA.

Replicating this Innovation: Our goal was for FQHCs to replicate these trainings to meet the unique needs of their site. The foundation of the Genomics Train the Facilitator sessions was a Facilitator Guide. This guide acts as a model for other partners in the All of Us consortium to create and facilitate their own trainings. The guide gives staff the template to host their own trainings independently and the skills to facilitate them effectively. The recordings and materials for each of these trainings are available internally for FQHCs that participate in the All of Us Research Program.
CP18
Factors Associated with Retention of Underrepresented in Biomedical Research Participants Within the All of Us Research Program at an FQHC
Poster Type: Research
Category: Demonstrating Value and Patient and Community Engagement
Research Objectives: Retention is a key aspect of longitudinal cohort studies; however, increasingly predominant use of digitized data collection methods present unique barriers for retention. The objective of our exploratory analysis aims to identify participant characteristics associated with “ever being retained” in the All of Us Research Program (AoURP), within an FQHC.
Study Design/Methods: A secondary data analysis was conducted among 2,000 adult participants enrolled in the AoURP at San Ysidro Health between July 2017 and March 2022. We examined ethnoracial identity as our primary independent variable along with multiple covariates including: gender identity, age group, language, educational attainment, years enrolled, as well as method of consent completion and owning an e-mail address which served as a proxy for digital skill for their known associations with long-term retention among populations underrepresented in biomedical research (UBR). Descriptive statistics along with bivariate and multivariate logistic regression models were performed using the statistical software Stata17.
Principal Findings and Quantitative/Qualitative Results: Approximately 64% of participants were retained. After adjusting for covariates, age groups above 36 years had higher odds of retention. Black/African Americans had lower odds of retention (Adjusted Odds Ratio [AOR] = 0.39, 95% Confidence Interval [CI] = 0.23, 0.67). Primary Consent completion in Spanish (AOR =1.78, 95% Confidence Interval: 1.34, 2.36), identifying as woman (AOR=1.84, 95% CI: 1.46, 2.33), and enrollment for 3 to 4 years (AOR=1.62; 95% CI 1.06, 2.50) each had greater odds of retention. Having a high school degree or experience had lower odds of retention (AOR=.62, CI: 0.45, 0.85 and AOR=.66, CI: 0.47, 0.94, respectively).
Conclusions on Impact on Health Centers: Consistent with previous research, we found significant associations between age, gender, ethnicity, and educational attainment with retention. However, having an email account or mode of primary consent (i.e., assisted, facilitated, or independent) did not reach significance indicating that digital skill alone may not influence retention. It is important to consider various social determinants of health that motivate participants in engaging in biomedical research. Our findings may inform local “recruit to retain” strategies to support the long-term retention goals of the AoURP within the context of FQHCs. These results may not be representative of or generalizable to the larger AoURP consortium.
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Presenter(s): Linda Salgin, Christian Rodriguez

Public Health Crises

CP19
Innovative 2D Barcoding Workaround Enhances Vaccination Best Practices in a Public Health Crisis
Poster Type: Innovation
Category: Public Health Crises
Issue or Challenge: Mass vaccination clinics for COVID-19 were challenged with managing multiple lots of EUA vaccine products, which lacked 2DBCs on the UoUs. To overcome this challenge, multiple 2DBCs could be generated per clinic day to uniquely identify each lot number (and its corresponding expiration date and NDC) in preparation for automated and accurate data entry for each lot’s administration at each clinic. This challenge was addressed with implementing the generate-print-post technique, so all vaccines were administered at stations with the correct custom-generated 2DBC available. The 2DBC could then be scanned to automatically and accurately enter that UoU’s lot, expiration date, and NDC. Each 2DBC print-out was also clearly marked to be human readable to avoid mistaken scanning.
Description of Innovation: Grand Forks Public Health (GFPH) partnered with Altru Health Systems for COVID-19 mass vaccination clinics (averaging 4,000 vaccinations per week) in North Dakota in spring 2021. This partnership created and implemented an innovative 2DBC workaround for COVID-19 vaccination clinics that resolved their data quality issues related to manually entering vaccine information with relatively minimal investment. They generated, printed, and...
posted 2DBC to replace the non-existent UoU 2DBC, allowing scanning at administration. Prior to implementation of the 2DBC workaround, the GFPH clinics were experiencing large numbers of data errors: one week had 451 records with data errors out of ~4,000 records. The cost of correcting one week's records' data errors prior to implementation of the workaround is estimated at $2,480, averaging 15 minutes of staff time per manually corrected record. The error rate dramatically reduced to 12 erroneous records one week post-implementation, and then to zero erroneous records two weeks post-implementation, with corresponding reductions in staff time and cost for the local health department. Additionally, the COVID-19 vaccination clinics were able to add up to 648 appointments per clinic per day due to innovations to their practice which included adding 2DBC scanning for data entry.

**Impact or Result:** Prior to implementation of the 2DBC workaround, the GFPH clinics were experiencing large numbers of data errors which incurred significant costs and required additional staff time outside of clinic hours to correct. The error rate dramatically reduced to 12 erroneous records one week post-implementation, and then to zero erroneous records two weeks post-implementation, with corresponding reductions in staff time and cost towards correcting data errors and redirection of staff time for the local health department. For example, the clinics were able to add up to 648 appointments per clinic per day for the community due to time savings related to innovations. Thus, the 2DBC workaround for EUA COVID-19 mass vaccination clinics resulted in value-based healthcare returns of time savings for staff, increased vaccination data quality, and decreased resources towards remediation of inaccurate/incomplete data. Increases in vaccinations possible per clinic day allowed more vaccinations to be administered, increasing population health.

**Replicating this Innovation:** Vaccine 2DBC scanning practices are proven to increase data quality across multiple clinical settings. The generate-print-post vaccine 2DBC workaround can be reproduced for any vaccination setting which would support 2DBC scanning for data entry. This may be most effective in cases where a provider is administering the same vaccine product(s) to many people, such as COVID-19 vaccinations, flu shots, or other vaccination clinics. Public health departments may adopt this innovative workaround to provide easy-to-scan 2DBCs and increase the quality of vaccine data in records.

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**CP20 Southern Colorado Rural Recovery Network**

**Poster Type:** Innovation

**Primary Funding Source:** Colorado House Senate Bill 21-137

**Category:** Public Health Crises

**Issue or Challenge:** The program initially launched in January of 2020, at the same time that the COVID-19 public health crisis was beginning. Lockdown orders were issued by the State of Colorado in March 2020 which drastically limited partner capacity to interact with patients in person. Because the majority of partners are medical agencies, many resources were redirected toward addressing the pandemic and other key staff were required to quickly transition to remote work. The partnership addressed these challenges by adapting new workflows to incorporate telehealth technology, shifting all meetings to virtual, and utilizing funding through the CARES Act to provide personal protective equipment (PPE) for both patients and partner staff. In addition, the program used CARES funding to purchase and distribute TracFones to patients which helped mitigate the access barriers manifest in telehealth.

**Description of Innovation:** Valley-Wide Health Systems, Inc. coordinated with regional medical providers and community service agencies to plan a patient-centered, collaborative partnership to increase capacity for, and access to, medication-assisted treatment (MAT) for opioid use disorder (OUD). The collaborative leveraged funding from Colorado SB 19-01 to recruit and train additional MAT providers, establish a shared care coordinator position to guide patients into care with the “best fit” provider, and address patient barriers to care through coordination with partner community service agencies. By integrating diverse partner specialties and capacities into a single program, the collaborative is able to provide increased access and customized treatment plans in alignment with patient needs, barriers, and life situation. Plans include options for treatment with Methadone, Buprenorphine, or Naltrexone with support for transportation, telecommunications, and other social determinants of health.

**Impact or Result:** The program provides a patient-centered model of care, in that multiple partners assist individual patients across medical, behavioral, and social aspects of recovery. This project strengthened relationships with community partners and improved patient access to SUD treatment. Since its inception in January 2020, the program has induced more than 286 patients into MAT. These inductions utilized the full spectrum of available MAT medications, with 70 using Methadone, 32 Vivitrol, and 184 Suboxone.

**Replicating this Innovation:** This program was uniquely designed to address the OUD crisis in a rural, sparsely populated region where poverty is widespread and access to care is fragmented between largely self-contained medical agencies. Given the vast land area where the target communities reside, it is not practical or cost-effective to establish new brick-and-mortar facilities to increase treatment capacity. Within the framework of primary care and existing
facilities using the community health center model, it is far more effective to examine and leverage the resources that already exist. As individual agencies, program partners can offer only limited treatment capacity within the framework of their own internal structure and operational objectives. By linking up these partners into a collaborative, the program is able to compensate for gaps in individual agency services by supplementing those offered through other partners.

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Presenter(s): Emelin Martinez

CP21
Exploring Health Center Presence in COVID-19 Mortality Bright Spot Counties

Poster Type: Research

Primary Funding Source: Health Resources and Services Administration (HRSA) under contract HHSH250201800033G

Category: Public Health Crises

Research Objectives: This study investigates if greater health center presence is associated with lower community-level COVID-19 mortality. Specific aims include identifying counties with lower-than-expected COVID-19 mortality rates (i.e., bright spots), exploring health center presence in these counties, and comparing their characteristics with counties that have higher-than-expected COVID-19 mortality rates.

Study Design/Methods: Using data from HRSA, USA FACTS, CDC, RWJ, and ACS, this county-level analysis included: health center presence (measured by low-income health center penetration rates), COVID-19 mortality per 100,000 population, COVID-19 vaccination rates, and the percentage of population that is rural, Black, ages 65 and older, and high school graduates. We performed a spatial regression modeling COVID-19 mortality rates with county-level COVID-19 vaccination rates while controlling for rurality, age, race, and education. Next, a residual analysis identified counties with lower-than-expected COVID-19 mortality rates (bright spots). Finally, we compared bright spot health center presence to counties with higher-than-expected COVID-19 mortality rates.

Principal Findings and Quantitative/Qualitative Results: Bright spot counties have significantly higher health center low-income penetration rates. The average low-income penetration rate for counties with residuals in the bottom quartile (bright spots) is 35.0% while counties in the top quartile (worse-than-expected) have average low-income penetration rates of 29.5%. Bright spot counties differ from higher-than-expected COVID-19 mortality counties in several ways. When compared to higher-than-expected COVID-19 mortality counties, bright spot counties have significantly larger populations, higher numbers of health center patients, higher percentages of Hispanic populations, higher percentages of renters, and higher percentages of people with severe housing problems, but significantly lower percentages of single-parent households.

Conclusions on Impact on Health Centers: Bright spot counties have stronger health center presence than counties with higher-than-expected COVID-19 mortality rates. These high-performing counties tend to have larger populations, more health center patients, and larger percentages of Hispanic populations. The Health Center Program provides care to socially- and medically-vulnerable populations, including population groups identified as being at higher risk of COVID-19 infection and mortality. This research suggests that greater health center presence may help to mitigate COVID-19 mortality rates in counties with larger proportions of vulnerable populations.

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CP22

Quality Suggestions: An EMR Nudge Toward the Quadruple Aim

Poster Type: Innovation

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

Issue or Challenge: Initial investment from team leaders was lacking as they expressed concerns that the number of suggestions could become overwhelming, however we showed an average of just over three topics per patient encounter which was deemed acceptable. Furthermore, we developed a process to obtain objective and subjective feedback from providers to continuously improve the suggestions, their format, and the transparency behind recommendations. This has led to consistently positive responses with 94% of surveyed providers reporting that they respond to the suggestions and 80% of respondents agreeing that the suggestions help them provide better care (15% neutral).

Description of Innovation: We created and implemented an innovative clinical decision aid called Quality Suggestions in Epic. This tool addresses almost 100 standards of care including: blood pressure control, high-risk medications use, and screening lab tests for immigrants and refugees. This novel tool creates patient- and context-specific clinical nudges by showing suggestions within the provider’s note. Since these are designed to be a clinical nudge and are not mandatory, the provider may choose whether or not to act upon these suggestions without penalty. The suggestions are constantly evaluated and expanded by a central team who evaluate new guidelines and target new patient populations. Feedback has consistently shown provider satisfaction, data demonstrates improved screening and more, and we continue to assess for the additional goals of decreased overall healthcare costs and enhanced patient care and satisfaction.

Impact or Result: We are constantly evaluating the impact the suggestions have had on provider behaviors, quality outcomes, and quality of care. Early data demonstrated a three- to five-fold increase in provider action on specific quality recommendations with these clinical nudges. Screening for conditions like osteoporosis more than tripled since pre-COVID pandemic compared to now in patients for which screening was recommended. Additional suggestions were made to improve safety and care of patients on chronic opioids. In January 2019 (pre-COVID), approximately 5% of patients on chronic opioids had a pain agreement, this number peaked at around 22% with addition of an electronic agreement. Since the implementation of the quality suggestions, reminding providers when patients on chronic opioids do not have a contract, this has steadily increased to 35% of patients. Steady increases in screening for communicable disease, AAA, and many other metrics continue since implementation.

Replicating this Innovation: To recreate this tool, organizations need to be using an EHR that allows logic rules to be imbedded in documentation templates.

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CP23

Utilizing EPIC Electronic Health Record to Auto-Populate Obstetrics Quality Improvement Measures During Prenatal Visits

Poster Type: Innovation

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

Issue or Challenge: The challenge in stage one of our project is collecting appropriate colleague feedback to ensure a comprehensive and relevant list of obstetrical reminders in EHR. We hope to achieve this goal by presenting in a structured focus group at local, state and national conferences, and then build out reminder recommendations for testing in EPIC. Validation testing and audits in the larger CHS provider group encounters will confirm if quality recommendations continue to show high value for both patients and providers.

Description of Innovation: A focus group comprised of Denver Health primary care providers created a working list of EPIC reminders for prenatal encounter documentation. This novel tool was recently implemented in ambulatory medicine/ pediatric encounters at Denver Health (2021). Reminders are built based on available, patient-specific EPIC data. While in an active patient encounter, the tool highlights clinically appropriate OB care recommendations based on the individual patient. The pop-up reminder text will disappear when the provider closes the note. However, reminders continue to pop-up for all subsequent encounters until the task is addressed or a provider documents an “opt-out” by patient decision. Topic reminders include various prenatal conditions that could be easily missed or need a greater degree of standard documentation. Examples include a patient with history of chronic hypertension and not on aspirin, or a patient with an abnormal 1-hour glucose tolerance test who needs follow-up testing. Next, a pilot group of providers will test the accuracy of reminders in prenatal encounters. During the project’s second stage, the tool is rolled out to all prenatal providers in our community health clinic network and outcome data is collected.

Replicating this Innovation: To recreate this tool, organizations need to be using an EHR that allows logic rules to be imbedded in documentation templates.

Author(s): Jessica Bull

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Impact or Result: This EHR tool is currently running in Denver Health ambulatory care for topic reminder in medicine and pediatric encounters. A manual chart audit of 100 encounters before implementation and 100 encounters after implementation looked at a completion rate for more than 620 quality topics. All provider types showed improved response to reminders and resident providers were more likely to respond. The OB reminders are currently in the build and validation phase of stage one and are expected to improve outcomes when audits start (stage two).

Replicating this Innovation: The EPIC quality reminders can be shared with interested primary care provider groups. The tool reminders can be turned on or off and set to a specific provider group or patient encounter type.

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Presenter(s): Melissa Beagle, Jessica Bull, Daniel Kortsch

Social Determinants of Health

CP24
Exploring Relationships of Maternal Social Risk, Delayed Prenatal Care, and Infantile Weight
Poster Type: Research
Category: Social Determinants of Health

Research Objectives: Given the association and potential impact of SDH on the incidence of low-birthweight (LBW) and accessing prenatal care, the purpose of this study is to identify if a relationship exists between the factors that increase social risk in mothers of LBW infants, therefore filling gaps based upon needs of the mother.

Study Design/Methods: Data were collected between January 2019 and December 2020 from a single CHC in the Midwest. The patient records used were those that were confirmed pregnant, and fully completed PRAPARE to generate a score (n=345). Using a chi-square analysis, the dichotomized predictor variables were compared with our outcome variables, both birthweight and initial prenatal exam (IPE). Logistic regression was used to explore associations between PRAPARE items and the trimester of the IPE. Adjusted odds ratio (aOR) and 95% CI were used to report findings. Significance was evaluated based on a .05 level.

Principal Findings and Quantitative/Qualitative Results: Only 19% of women sought care during their first trimester, and of that 62% of those who delayed their IPE also reported a social risk score greater than “low-risk”; however, no significant relationship was found (p=.87). Finally, a relationship was not found to exist between those who delay IPE and the resulting birthweight of the child after birth (p=.48). There was no relationship found between the overall PRAPARE score and the fetal birthweight (p=.85). Additionally, after looking at fetal birthweight and each measure of PRAPARE, no significance was found. More detailed results to come after further analysis takes place.

Conclusions on Impact on Health Centers: By knowing the predictors of the patients that may delay IPE, providers at CHCs can use this information to tailor their patient visits. Providers at CHCs can reassure patients that although IPE was delayed, the potential weight of their infant may be of average weight (2500g-4000g). Further, the importance of identifying social risk factors has known benefits beyond that of how it relates to prenatal health. More advanced analysis is needed to seek the nuanced relationships between the individual items of the PRAPARE tool and the patient’s IPE and ultimately the birthweight of the baby after delivery.

Author(s):
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Presenter(s): Abbie Luzius

CP25
An Innovative Approach to Addressing Health-Related Social Needs
Poster Type: Innovation
Category: Social Determinants of Health

Issue or Challenge: One of the largest challenges with this innovation, and with screening for health-related social needs (HRSNs) in general, is the management of identified needs. While we increased identification of needs, no additional resources went to the community-based organizations (CBOs) to help them manage the influx. Innovations such as these require the creation of strong partnerships between health systems and CBOs to advocate for additional funding and resources to be allocated to the CBOs. Another challenge involved data sharing and integration between DRCOG and Epic, the EHR. In order to address this challenge, we did not use the secure MyChart portal to screen. However, the data then needed to be manually entered into the medical record.

Description of Innovation: When the pandemic started, the primary care clinics pivoted to telehealth visits very rapidly and everything about the delivery of primary care needed to adjust.
The usual medical check-in was significantly modified. Due to the rapid transition, workflow was not initially developed to include the screening tools that would normally be distributed at regular primary care office visits. At the same time HRSNs increased dramatically, disproportionately impacting the patients seen in the Denver Health system. In an attempt to meet increasing HRSNs within an environment of limited face-to-face contact with patients, we added an email campaign to our current primary care visit-based HRSN screening. Patients who had a primary care visit in the previous 3 months on a rolling basis and had an email address on file received an email with the screen attached, and instructions to complete. If a need was identified, a customized community resource summary was emailed back to the patient. A patient who reported 2 emergency department visits plus an HRSN was eligible for navigation, so they received a call from a centralized navigator hired by the Accountable Health Communities bridge organization, Denver Regional Council of Governments (DRCOG).

**Impact or Result:** The e-campaign used an innovative approach to identify and address HRSNs during the unprecedented pandemic. Of the 78,140 emails sent, we received 6,053 completed screenings representing an 8% response rate. Based on similar projects, we were expecting a 3% response rate. Seventy percent of returned screenings reported a need which included 55% with food insecurity, 41% with a housing need, 29% with a transportation need, and 16% with a utility need. There was a larger number of navigation-eligible beneficiaries (22%) compared to other screening modalities. The majority of individuals responded to the screening within the first 24 hours of receiving the email. Presumably due to the more private nature of self-administering the screening online compared to being in a healthcare setting or answering the screening questions over the phone, the e-campaign reported more beneficiaries with a safety need (4%) than other screening modalities.

**Replicating this Innovation:** Replication of this innovation requires a close partnership with CBOs that are willing and able to manage an influx of identified needs. It also requires a system that collects email contacts and has the data capacity to securely send outreach to addresses. This innovation also requires an organization and leadership team that understand and appreciate the impact of health-related social needs on populations served and recognize the role of the medical system in addressing these needs.

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**Presenter(s):** Margaret Tomcho

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

**CP26**

**Using Technology to Improve Health**

**Poster Type:** Innovation

**Category:** Expanding Access to Care and Other Services, Improving Care for Special Populations, Patient and Community Engagement, and Technological Solutions and Tools to Improve Care and Population Health Management

**Issue or Challenge:** It took about one year from the initial idea for this project to realization. Some of the delay was due to the pandemic which prevented holding the initial in-person classes. Additionally, a partnership had to be formed between the two entities, Denver Health and Denver Housing Authority. Then the identification and evaluation of a location for an initial pilot that would meet the requirements of a private space that was accessible to all residents, with wired internet capabilities that was large enough to accommodate residents and technology, presented a challenge that was overcome. Support from local leadership at both Denver Health and Denver Housing Authority was important to the success. And most importantly, the residents' access to internet and devices was a major barrier. To overcome this, the educational classes were developed and the special computer was installed.

**Description of Innovation:** The project engaged seniors and people with disabilities, at a Denver Housing Authority residence, in a classroom training session focused on digital literacy and chronic disease management. The initial session taught residents how to use the electronic patient portal, MyChart, to schedule appointments, check labs, and enter information. It also taught residents how to take their own blood pressure and understand blood pressure readings. At the end of the session, residents were encouraged to schedule a virtual video visit with a provider. To facilitate this, Denver Health partnered with the Denver Housing Authority to set up a private room with internet access, with a special computer provided by Denver Health, where residents could have a virtual video visit with a provider. During the initial pilot, a medical assistant was present at the Denver Housing Authority to perform a standard check-in process and assist patients in the use of the technology. The patient then had a video visit with the provider. If the resident had a device and internet in their unit, they were able to conduct a video visit from their
phone or tablet with the knowledge and support they gained from the educational session.

**Impact or Result:** The initial two educational sessions were extremely successful. Residents of the Denver Housing Authority were engaged. Participants that indicated they understood hypertension increased from 32% pre-class to 89% post-class. Post-sessions, 75% of participants said they would be interested in using more technology to improve their health. Residents showed interest in ongoing classes focused on other topics like diabetes management. The video visits were also successful and feedback was positive. Before the pilot, 65% of residents were engaged in healthcare with Denver Health. The project allowed patient residents to avoid a trip to a brick-and-mortar clinic. For residents that were not already patients of Denver Health or another institution, this allowed for an additional modality to engage with healthcare. The potential to manage chronic disease by using self-monitoring tools and video visits, while avoiding sometimes challenging trips to a physical location, is a great benefit for elderly patients and those with disabilities.

**Replicating this Innovation:** After having success with this pilot at one location, the plan is to expand to additional Denver Housing Authority resident buildings. Key to the success of this project is the partnership created between the healthcare provider at the community health center and the local housing support organization. It is as important to have local leadership support and clinical partnerships. Lastly, it’s important to simplify the process and workflow as much as possible for the patient and the provider.

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**Presenter(s):** Haddas Lev, Deep Shah

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**Workforce**

**CP27**

**Eisner Health’s Journey Through Implementing Trauma-Informed Care**

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

**Issue or Challenge:** The inward facing approach that Eisner Health took to trauma-informed care has required patience, relationship-building, trust, and a culture that supports those qualities. The leadership team modeled trust and transparency through internal communication and supporting ongoing training with staff with Eisner Health’s trauma-informed care coordinator. Some team members continue to have a difficult time grasping that trauma-informed care is an approach and not a clinical intervention. The term “trauma-informed” was difficult for some staff to understand due to the medical field’s definition of trauma or a person’s historical experience of the approach being focused on patient care. Ongoing training and communication has supported the shared language and some rebranding of the implementation teams as “resilience team.” Eisner’s rapid growth and planned expansion has impacted the culture of the organization. Each implementation team considered the needs of each site including team dynamics and service delivery during its rollout. The power dynamics baked into the systemic design were also addressed. The internal communication from leadership included clinic specific listening sessions where staff could voice their concerns and needs. Issues like pay, physical safety related to COVID, and discrepancies between how each clinic practices were brought up and addressed.

**Description of Innovation:** Implementing trauma-informed care started in 2018 when Eisner Health received two grants from the Health Resources & Services Administration to fund training and the hiring of a dedicated trauma-informed care coordinator. The implementation plan included an informal assessment, training sessions, and staffing considerations as well as the coordination of services among departments within the clinic (dental/medical/behavioral health). This model was duplicated and modified at various sites. The process included initial assessment and buy-in from organizational leadership. Trainings introduced staff to the concepts of a trauma-informed approach including learning about the impact of adverse childhood experiences (ACEs) and toxic stress, and the role of protective factors and resilience, and also provided opportunities to build and practice stress management skills. A champion team for each clinic site was then established to support the ongoing implementation of the approach. This team included staff from all roles within the clinic. At some sites, a patient was also included in the group to help provide feedback on what was working well and identify opportunities for improvement.

**Impact or Result:** Eisner Health experienced a reduction in both the number of complaints from staff and patients as well as the number of incidents (such as escalations to a supervisor and security being called). Staff shared that they felt more capable of empathizing with patients and peers and attributed the change to the training workshops. Other team members noted subtle ways that Eisner Health is making progress, such as improving language on the organization’s website and the types of posters on the clinic walls. An increase in felt safety was reported by staff. The impact was not only professional. Many team members reported an increase in mindfulness and self-insight, enhanced personal relationships, and improved approaches to parenting.

**Replicating this Innovation:** A key ingredient to successful integration of a trauma-informed approach is defining a high-level vision or purpose for wanting to do it. Eisner Health had a
clear “why” and a champion within the leadership to guide the process. Training all staff on the basic concepts of the approach can support the development of a shared language across the organization. Other key lessons include:

- Define what trauma-informed care is and is not.
- Put dedicated staff in place to lead, if possible.
- Include staff from all departments in a variety of roles to allow for consideration of how the concepts can be translated into practice with a focus on staff wellness first. Also, including the patient voice whenever possible.
- Focus on building cross-functional and cross-department relationships within the organization to support innovation. Approach the process in a way that meets both the site’s needs and the culture of the organization.

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Whisenant, Ebony - CP5
Whitner, Jangus - CP8
Williams, Ladrea - CP16
Willis, Taylor - CP6

Yazel, Eric - CP11
Hyatt Regency Chicago
Poster Presentations

Sunday, August 28, 2022, 5:00pm – 6:30pm • Monday, August 29, 2022, 12:30pm – 1:30pm
Riverside Exhibit Hall
Upcoming NACHC Conferences and Trainings

MARK YOUR CALENDARS!
Check back regularly to see which events will include virtual streaming!
(AS OF JULY 1, 2022 AND SUBJECT TO CHANGE)

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

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<td>Financial, Operations Management/Information Technology (FOM/IT) Conference &amp; EXPO Preconference Workshops: October 29</td>
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<td>PCA &amp; HCCN Conference</td>
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<td>August 27-29, 2023</td>
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<td>Policy &amp; Issues Forum (P&amp;I) Committee Meetings: February 3-4, 2025</td>
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To register for these and future trainings, visit us at [http://nachc.org/trainings-and-conferences/](http://nachc.org/trainings-and-conferences/).

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

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