



**Abstracts from the**

**2014 NYC RING**

**Convocation of Practices**

Thursday September 11, 2014



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# About New York City Research and Improvement Networking Group (NYC RING)

The New York City Research and Improvement Networking Group (NYC RING) was formed in 2003. It is a practice-based research network sponsored by the Department of Family and Social Medicine of Albert Einstein College of Medicine. To date, NYC RING has built a partnership of 36 practices in the Bronx and Manhattan sponsored by six medical centers, and one private practice, providing over 500,000 visits to primarily low-income, minority primary care patients.

Similar to other practice-based research networks nationwide, NYC RING is a voluntary association of practicing clinicians collaborating to improve quality-of-care through research or quality improvement in their offices. We carry a unique goal of focusing solely on the issues of underserved urban communities through research initiatives and quality improvement projects. Some critical elements of NYC RING projects include:

- Clinically relevant to urban primary care
- Potential to change practice
- Results fed back to practices
- Respectful to clinician time and practice realities
- Opportunity for clinician and staff input at all phases

We welcome both *new member practices* and *collaborators* working on research topics appropriate for the practice-based setting to join our network of partner sites.

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Please visit our website at [www.nycring.org](http://www.nycring.org) to learn about our goals and projects

# NYC RING PRACTICES

## **Bronx-Lebanon Hospital Center**

- Fulton Family Practice Center
- Ogden Family Medical & Dental
- Crotona Park Family Practice
- Wellness Center

## **Institute for Family Health**

- Mt. Hope Family Practice
- Parkchester Family Practice
- Urban Horizons Family Health Center / River Counseling Center
- Walton Family Health
- Westchester Avenue
- Amsterdam Center
- East 13th Street Family Practice
- Phillips Family Practice
- Sidney Hillman Family Practice

## **Jamaica Hospital Medical Center**

- Family Medicine Residency Program

## **North Bronx Healthcare Network**

- Health Care Center at Gun Hill
- Health Care Center at Tremont
- Health Center at Glebe

## **Private Practice**

- Riverdale Family Practice

## **Saint Joseph's Medical Center**

- Family Health Center

## **Urban Health Plan, Inc.**

- El Nuevo San Juan Health Center
- Bella Vista Health Center
- Plaza Del Castillo Health Center

## **Montefiore Medical Group**

- Astor Ave Pediatrics
- Bronx East
- Castle Hill
- Comprehensive Family Care Center (CFCC)
- Comprehensive Health Care Center (CHCC)
- Co-op City (Bay Plaza)
- Co-Op Dreiser Loop
- Family Care Center (FCC)
- Family Health Center (FHC)
- Fordham Family Practice
- Grand Concourse
- Marble Hill Family Practice
- Riverdale
- South Bronx Children and Family Health Center
- University Avenue Family Practice
- West Farms Family Practice
- White Plains Road
- Williamsbridge Family Practice
- South Bronx Health Center for Children and Families

# 2014 NYC RING Convocation of Practices

“Integrating Behavioral Health in the  
Patient Centered Medical Home”

**Thursday September 11, 2014**

## Agenda

4:30 - 5:00 pm **Registration**

5:00 – 6:00 pm **Welcome**

**Peter Selwyn, MD MPH**

*Chair, Department of Family and Social Medicine*

### **Keynote Address**

**Macaran Baird, MD MS**

*Head of the University of Minnesota Department of Family  
Medicine and Community Health*

### **Closing Remarks**

**M. Diane McKee, MD MS**

*Associate Professor and Co-Director Division of Research,  
Department of Family and Social Medicine*

6:00 – 7:30 pm **Poster Presentations**

First Round: 6:30 – 7:00pm

Authors of **even**-numbered presentations stay by their  
presentations

Second Round: 7:00 – 7:30 pm

Authors of **odd**-numbered presentations stay by their  
presentations

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## Abstracts

### Chronic Disease

#### Presentation #1

##### **Simulating Patterns of Patient Engagement, Treatment Adherence, and Viral Suppression: A System Dynamics Approach to Evaluating HIV Care Management**

David Lounsbury, PhD; Brian Schwartz, MPH; Anton Palma, MPH; Arthur Blank, PhD

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Systems thinking and system dynamics modeling belong to the rapidly evolving, interdisciplinary field of system science research. This field adds value to more traditional health research methods by contributing to the design and testing of integrated models of change, to examine how key factors interact impact health status. Using the 'stages of care' as a framework for our simulation research, we created a system dynamics model to examine three patient subgroups of women of color living with HIV who were represented in a patient cohort, classified by their health care seeking status at baseline. Asked to reflect on their circumstance six months prior to enrollment in the MSE cohort, 53% noted they were receiving some care (In Care, n=341), 30% that they had been seeking care (Seeking Care, n=201), and 17% that they were undecided about seeking care - i.e., answered that they may or may not look for care - for treatment of their HIV (May or May Not Seek Care, n=103). Our system dynamics model was designed to enable comparison of simulated patterns of patient retention, in relation to achievement of viral suppression, for the three patient subgroups over a specified time period. Comparison of patterns for these groups yielded insights about system capacities and constraints, in the context of the a multi-site evaluation of demonstration projects funded by the Health Services and Resources Administration (HRSA).

#### Presentation #2

##### **Determining the extent to which Diabetes Fatalism mediates the relationship between Depression and Diabetes Adherence and Control**

Diane Rhoden, MD; Joyce Tibbet, DO; Fahim Tazwar, MD

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Diabetes is a chronic, life threatening condition. Diabetes is epidemic in NYC and prevalence has doubled in the last 10 years with 12.5% of adults in NYC diagnosed with Type 2 Diabetes. Risk factors for type II diabetes include among other factors, depression and low socioeconomic status. Diabetes management is complex and requires adherence to both medication and dietary regimens. Both low SES and depression are associated with poor adherence. However poor adherence has also been explained by the construct of Diabetes fatalism which happens to Diabetics who feel powerless to change the course of their illness. The aim of this study is to test the hypothesis that diabetes fatalism mediates the relationship of depression to adherence to both dietary and medication regimens and glycemic control among patients with Type II diabetes, served in an urban primary care practice. We will test this hypothesis both concurrently and prospectively. At time 1, we will examine concurrent relationships of depression, fatalism, and diabetes dietary adherence, medication adherence and diabetes control (HbA1c) in a sample of 100 patients drawn from JHMC primary care practices. We will also collect data six months

later at Time 2 and examine whether changes in depression affect fatalism. These data can provide mechanistic information needed to guide interventions to improve adherence in a high-risk sample.

### Presentation #3

#### **Glycemia Reduction Approaches in Diabetes: A Comparative Effectiveness Study (GRADE)**

Jennifer Lukin, BS; Vlad Velicu; Shira Hudes; Janet Brown-Friday, RN MSN MPH; Eni Xhori, MA MS; Ella Rosenbloom, MD; Jesse Liu, PhD; Jeremy Miles, BA; Gabriel Castillo, BA; Stephanie Behringer, MD; Rachel Bier, MD; Maria Naranjo, MD; M.Diane McKee, MD MS; Jill Crandall, MD  
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**Background:** In 2012, diabetes affected 9.3% of the US population and 10.7% of the NYC population. The Glycemia Reduction Approaches in Diabetes: A Comparative Effectiveness Study (GRADE) will address this issue in a national randomized clinical trial, sponsored by the National Institutes of Health, in patients with recent-onset type 2 diabetes that will compare the effectiveness of four common anti-diabetic drugs when combined with metformin. The ongoing study compares these drug combinations over a clinically meaningful duration, with a mean follow-up of 4 to 7 years. The national study aims to enroll 5000 participants (150 of those at Einstein). **Methods:** In our recruitment effort, the Principle Investigators (PI's) meet with primary care providers (PCP's) to introduce the study and address questions. We then utilize a REDCap database created by our informatics specialists, which is designed to capture all patient contact and pertinent clinical information. The database is created by querying the electronic medical records (EMR) of the Montefiore Medical Center, which includes multiple primary care clinics and practices. Patients who meet basic eligibility criteria are called for telephone screening, under the authorization of the PCP. Criteria include having diabetes for <10 years, A1c between 6.8 -8.5, and taking metformin to treat their diabetes. After completing a prescreening questionnaire during an initial phone call, the potential study participants are invited for an on-site screening visit. Study visits are conducted at the Clinical Research Center at Einstein. **Results:** As of August 2014, our site has screened 207 participants, 50 of whom have been randomized to one of the four study medications. **Conclusions:** We believe that the recruitment efforts have been successful thus far due to the close relationship that the PI's maintain with the PCP's, the frequent site visits made by the study staff, and the diligent involvement of the PI's through weekly recruitment meetings. Another important contributing factor is the continuous utilization of the up-to-date EMR, which allows smooth communication between the staff, PCP's, and PI's.

### Presentation #4

#### **Acupuncture to Decrease Disparities in Outcomes of Pain Treatment**

Benjamin Kligler, MD; M. Diane McKee, MD; Jason Fletcher, PHD; Arthur Blank, PhD; Francesca Biriukov, MS, Lac; Giselle Campos, BA  
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**Purpose:** To describe outcomes of the Acupuncture to Decrease Disparities in Outcomes of Pain Treatment (ADDOPT) trial, testing acupuncture as an adjunct to usual treatment for chronic pain in urban health centers. **Method:** We conducted quasi-experimental trial. Primary care patients (>21 yrs) with chronic pain due to osteoarthritis, neck or back pain at four hospital owned safety net health centers in the Bronx, NY received weekly acupuncture treatments provided by supervised acupuncture students

for up to 14 weeks. Pain and functional status were assessed during a 6-week run-in period before acupuncture, during treatment and post treatment. Results: Of 495 referred patients, 226 (47%) initiated acupuncture. Back pain was the most common referring diagnosis (59.5%) followed by OA (16.3%). Patients were older (mean age 54.3), mostly Medicaid insured (60.4%), often on disability (38.3%), often (46.7%) in poor or fair overall health, and had high baseline levels of pain (mean BPI pain severity 6.8; mean days with pain, 12.3 of 14 days). The mean number of treatments was 9.7 (SD = 7.3). Pain severity improved from baseline (6.8 vs 5.6 at 12 wks and 5.5 at 24 wks) as did physical well-being (31.8 vs 35.7 at 12 wks and 35.3 at 24 wks). Using HLM methods, reduction in pain severity between baseline and treatment phase was significant ( $p < .001$ ). Improvements in physical well-being were significant at 12 and 24 weeks post-baseline ( $p < .001$ ). Conclusions: Referred primary care patients experienced high levels of pain and pain-related disability. Weekly acupuncture was associated with short-term improvements in pain and quality of life.

## Presentation #5

### **Kidney Care Program in an Urban Managed Care Setting Prepares CKD Patients for ESRD**

Terrian Smith-Jules, RN, FNP-BC; Lendita Prlesi, Pharm D; Joseph Manganelli, Pharm D; Henry Chung, MD; Anne Meara, RN, MBA; Tanya Johns, MD; Carolyn Bauer MD

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The prevalence of End Stage Renal Disease (ESRD) in the Bronx is higher than the average prevalence of ESRD in the US. Timely vascular access placement reduces morbidity, mortality and is cost effective. Incident hemodialysis initiation is associated with high rates of hospitalizations. The Kidney Care Program (KCP) at Montefiore is a multidisciplinary clinic for patients with advanced Chronic Kidney Disease (CKD). In addition to usual nephrology care, this program offers patients care coordination from a nurse practitioner, educational classes, pharmacist medication reconciliation, dietary counseling, geriatric and palliative care assessments, navigation through dialysis preparation and listing for kidney transplantation. In its first year, KCP provided nurse practitioner evaluations to all of the 155 enrolled patients, renal dietician evaluations to 16%, a geriatric palliative care evaluation to 45% of patients over age 80 or with multiple co-morbidities, and a pharmacy evaluation to 91% of its patients. Patients had polypharmacy use (85%) (>8 medications) and 47% were non-adherent. Of the drugs considered inappropriate by the pharmacist, 39% of prescription drugs and 9% of OTC drugs were discontinued. Pharmacist recommended one or more dosing changes in 35% of cases, and doctors implemented 46% of those changes. Formal Group educational sessions were attended by 35 percent. Of KCP patients, 14% (21) progressed to ESRD within one year. One patient was transplanted and 2 patients opted for peritoneal dialysis. Of the 18 patients who started hemodialysis, 50% were started as outpatients, compared to 34% historical rate in prior years (2007-2011.) During the 1st dialysis, 56% (10) of patients had an AV Fistula/AV Graft in use. In addition, either a mature or maturing vascular access was present in 94% (17) of our hemodialysis patients. A multidisciplinary approach to CKD care facilitated outpatient dialysis initiation and improved AVF rates. Pharmacy evaluations led to discontinuation of inappropriate medications and improved medication dosing. These results suggest that multidisciplinary care can improve outcomes as patients transition from CKD to ESRD.



**Presentation #6****The Chronic Care Model and Patient Assessment of Chronic Illness Care (PACIC) in Dentistry**

Julie Kazimiroff, DDS, MS; Glenda Rodriguez-Aguiar, DMD; Paul Meissner, MSPH; Nicolas Schlecht, PhD

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Context: Dental services are increasingly recognized as complimentary to medical care and acknowledged as part of the Chronic Care Model (CCM). The Patient Assessment of Chronic Illness Care (PACIC), a validated, primary care assessment instrument is used to measure patient centered outcomes in medical settings. These outcomes include satisfaction with care and whether it aligns with the CCM. We report on the use of the PACIC instrument for assessing dental patient centered outcomes. Objective Design: 1) Provide a baseline evaluation of whether patients receive patient-centered, proactive, planned care that includes collaborative goal setting; problem-solving and follow-up support in the dental setting; 2) Assess the validity of using the PACIC survey in dental settings by comparing baseline dental outcomes to baseline medical outcomes. Setting: Dentistry-Use PACIC data to improve dental patient satisfaction with care and outcomes. Participants: During a 3-month period (2012), 563 adults reporting one or more chronic illnesses were randomly selected from approximately 14,500 unique dental patients who received dental care at an urban, inner city academic health center. Instrument/Intervention: These adults completed the 20-item PACIC survey, which measures patient activation (items 1-3), delivery system design/decision support (items 4-6), goal setting (items 7-11), problem solving/contextual counseling (items 12-15), and follow-up/coordination of care (items 16-20). PACIC rating consists of a 5-point Likert scale and an overall summary score. Results: We compared the overall summary PACIC scores from the dental patients to those reported in the medical literature. In our survey, baseline mean dental PACIC values ranged from 2.79-3.12 (Standard Deviation (SD) = 0.14) compared to baseline medical range 3.25-3.46 (SD = 1.21). Conclusion: The PACIC appears to be a practical, reliable instrument for assessing dental patient satisfaction with care and outcomes. PACIC may be a valuable tool for bringing CCM concepts into the dental setting.

**Presentation #7****Intensive Case Management for People with Poorly Controlled Diabetes at a Family Medicine Residency Practices - Interdisciplinary Care, Coordination and Education**

M-L Fabienne Daguilh, MD; Sandra Barnaby, RN /CDE

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Based on principles underlying the Chronic Care Model and the Patient-Centered Medical Home, interdisciplinary teams focused on people with poorly controlled diabetes which have been evolving at Montefiore's Family Medicine Residency Practice, Williamsbridge Family Practice. Initial team development was supported by the American Association of Medical Colleges Chronic Care Collaborative in 2006. Ongoing team development and 'spread' have been funded by HRSA Title VII residency training grants and by support from Montefiore's Care Management Organization. The teams relies on interdisciplinary expertise, frequent visits, a focus on mental and behavioral health, and outreach to overcome 'clinical inertia' in the care of people with diabetes and A1C's>8. Also included in the team are a variety of learners, including residents in family medicine and a health psychology intern. The intensification process has been able to generate both short and long term improvements in A1C and

continuity of care. Next steps at Williamsbridge include continuity of care by the interdisciplinary team, decreasing wait time for ICM appointments with a CDE as the driver, increase focus on self-management goals, and developing new and innovative programs for exercise. This work owes its success to team members: Victoria Gorski, M-L Fabienne Daguilh, Sandra Barnaby, Anne Keillor, Ashley Fellows, Terrian James, Justyna Zapolska, Jennifer Leone, Tanya White-Davis, Josephine Minardo, Jennifer Egert, Eliana Korin, Blanche Doati, Henry Chung, Anne Meara and Sheila Felleman

### **Presentation #8**

#### **Establishing the Bronx Minority/Underserved Community Site for the National Cancer Institute's Community Oncology Research Program (NCORP): New Opportunities for Collaborative Cancer Prevention and Control Research in Primary Care**

Bruce Rapkin, PhD; Diane McKee, MD; Joseph Sparano, MD; Mark Einstein, MD

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In August 2014, Montefiore and Einstein were awarded a grant to establish a National Cancer Institute Community Oncology Research Program (NCORP) Minority Community site in the Bronx. NCORP will work with national clinical trials groups to design and conduct cancer therapeutic, prevention, control, and screening trials, as well as cancer care delivery research at the patient, clinician, organization, and systems level. NCORP will integrate disparities research questions across all types of studies; combine primary care providers' expertise with oncologists; and accelerate knowledge transfer into practice. The NCORP grant will provide an important opportunity for expanding cancer-relevant research in primary care in the Bronx. In addition to working closely with NYC-RING, our site will encompass work with the Montefiore CMO/ACO to examine innovative models of care management, delivery and financing. We will also build upon our affiliations with the North Bronx Healthcare Network and community FQHCs. The specific aims of the Montefiore-Einstein NCORP are to: 1. Participate in NCORP's cancer prevention, screening, post-treatment surveillance, control, delivery, and treatment trials as well as sub-studies in health related quality of life, correlative science, and biospecimen collection; 2. Provide scientific and administrative leadership in trials sponsored by affiliated national research bases (including the Eastern Cooperative Oncology Group), including contribution of studies initiated at our site; 3. Expand our program in cancer care delivery research, encompassing prevention and screening in primary care as well as treatment and support for cancer patients; and, 4. Leverage existing resources to train and mentor young investigators for careers in all areas of cancer research encompassed by the NCORP. NYC-RING affiliates are encouraged to consider opportunities for participation in cancer-relevant research in primary care through participation in NCORP projects and activities.

### **Presentation #9**

#### **The Medical Home Transformation: The Montefiore Medical Group**

Namita Azad, MPH

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The Patient Centered Medical Home (PCMH) is a model for the provision of comprehensive preventive and primary care proven to improve health quality and efficiency and reduce disparities. For the patient, a PCMH provides a regular source of primary care, providing better health outcomes at a lower cost. The approach the Montefiore Medical Group (MMG) has taken to achieve PCMH success has been about moving away from reactive care to more proactive population management which includes more focus

on care coordination and transition management, follow-up between visits, chronic care outreach and patient education and activation. The population MMG serves is one of the most diverse in the country and in the year of 2013, the 22 MMG sites had 274,500 unique patients and 868,434 patient visits. The transformation has been accomplished by a multitude of processes which include, increase diversity of staff at sites, the formation and implementation of a coaching team supported with meaningful data reporting at site and physician levels and best practice sharing at routine collaboratives and seminars. The on-site coaching team has been key in driving the transformation with continuous needs assessments, workflow designing and implementation and training. MMG has seen success in metrics such as medicaid readmission reduced from 32% to 11% through the year of 2013, pneumovax rates increased from 67% to 89%, depression screening of ages 18 and older from 72% to 98%, UTD combo 3 vaccinations from 40% to 68% patient access from 10% in 2007 to 69% through 2013. As of July 2014, 21 of the 22 MMG sites have been recognized as PCMHs and this transformation has generated \$17.9million and is projected to bring in revenue of \$4.9million per year moving forward. Moving forward, MMG will increase focus on meaningful PI and enhancing patient experience and engagement.

## Presentation #10

### **CoPILOTS: A Collaborative Pain Intervention for Long-term Opioid Treatment Safety**

Serena Roth, MD; Sarah Ricketts, MD; Naum Shaparin, MD; Darlene DeSantis, PhD; Charleen Jacobs, NP; Joanna Starrels, MD

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Context: Among patients with chronic pain, comorbid mental health and substance use problems are common, and lead to poor pain outcomes and greater risk for opioid analgesic misuse. Primary care providers (PCPs) lack the necessary training, time, and support to optimally manage chronic pain, mental health and substance use disorders. Objective: To develop and pilot a collaborative care model for chronic pain management in primary care. Intervention: The Collaborative Pain Intervention for Long-term Opioid Treatment Safety (CoPILOTS) engages a multidisciplinary team of providers to improve patients' pain, function, and behavioral health. The CoPILOTS team includes a pain care manager (nurse practitioner), behavioral health manager (psychologist), two primary care champions (PCPs), a psychiatrist and a pain specialist. The program includes monthly pain and opioid assessments with recommendations to the PCP, a patient self-management program (Power Over Pain classes), mental health and substance use screening, treatment with the behavioral health manager if indicated, and facilitated referrals for specialty services. Setting: Montefiore Family Care Center (FCC) Internal Medicine Practice Participants: Adult patients who are prescribed long-term opioids (>3 in prior 6 months) for a chronic pain condition, and have suboptimally controlled pain or psychosocial challenges. Planned analysis: Using EMR data, interrupted time series analysis and non-FCC controls, we will determine whether CoPILOTS is associated with: 1) improved screening for mental health and substance use problems (e.g., with PHQ-9, GAD-7, AUDIT-C) among patients prescribed opioids for chronic pain; 2) improved use of safer opioid prescribing practices (treatment agreements, urine drug testing); and 3) improved patient pain, functional (PEG, Roland, Sheehan) and substance use outcomes (COMM). Feasibility outcomes will include patient and provider acceptability and satisfaction. Implications: Collaborative care for chronic pain management has potential to improve care for complex patients with chronic pain and behavioral health problems. If successful, CoPILOTS may be a model for care delivery in other primary care settings.

**Presentation #11****Group Medical Visits for Buprenorphine Maintenance in Primary Care**

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Context: Buprenorphine Maintenance Treatment (BMT) is effective in primary care, but patient engagement and outcomes are limited by competing priorities and structural barriers for patients and providers alike. Group medical visits (GMVs) offer a promising approach for BMT delivery for high-needs patients with opiate dependence. Objectives: To develop and implement a group medical visit intervention for BMT delivery in an urban primary care clinic; to assess feasibility and acceptability of this intervention; to assess process measures and clinical outcomes for this intervention. Intervention: We developed and implemented a biweekly group medical visit intervention for high-needs BMT patients in a primary care clinic. Working closely with a team comprising a primary care physician, medical student, social worker, clinical pharmacist, and nurse, we facilitate biweekly 90-minute sessions, focusing both on medical and psychosocial needs of our patients. Each visit includes patient self-assessment, meditation, education, individual reflection and group support, and a cognitive-behavioral/harm reduction module. Each patient receives a brief medical assessment, and receives his/her buprenorphine prescription according to his/her individual treatment plan. Participants: Patients are referred by their primary care provider due to extensive psychosocial needs and ongoing substance use despite standard individual buprenorphine maintenance treatment. Results: Of 33 patients referred, 20 attended at least one group visit, and 13 attended at least two sessions. Group census ranged 4-10 attendees (median of 6 patients per group). In addition to opiate dependence, most participants have concurrent diagnoses of chronic medical and mental illness. Approximately 1/3 of participants are HIV-positive. Conclusions: The Group Medical Visit model is an acceptable and feasible way to deliver BMT in a primary care setting. Optimal intervention structure and best practices must be established in the future.

**Presentation #12****The Role of Families and Their Effects in Latinos with Asthma and Panic Disorder**

Lynne Matte, PhD; Bari Scheckner, MA; Alejandro Interian, PhD.; Jonathan Feldman, PhD

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This study investigates the role and influence family members have on adults diagnosed with asthma and panic disorder. Prior research has indicated that the value of familismo largely impacts health behaviors among Latinos and may include both positive and negative influences (Ayon et al., 2010; Chavez-Korell et al., 2013; Davila, et al., 2011; Goldstein, et al., 2004). Understanding the consequences of the interaction and experiences of family members on participants diagnosed with comorbid disorders may be central to developing and implementing successful health interventions in Latino populations. Methods: Focus groups were conducted with a sample of 20 Latino adults with asthma and panic disorder. Qualitative analyses of these focus groups were conducted via open coding, in order to uncover issues related to the influence of Latino families. Transcripts from focus group participants were analyzed using a grounded theory approach. Results: Three major themes emerged : i. family as a source of stress ii. family in a caring role, and iii. family as an incentive. Discussion: These themes led to understand the family interactions as both detrimental or beneficial to the patients' mental and physical health. Thus leading participants to qualifying their asthma as emotional caused by an interaction with a family member, or using positive coping skills at the urging of their family members or feeling motivated to take care of themselves for their family. Two of the three themes depicted positive experiences which led to positive

outcomes on the participants' asthma and panic behavior. Therefore, the role of family and their effect had more of a positive impact than a negative one on the participants' cormobid disorder.

### Presentation #13

#### **Improving HIV Treatment Adherence Using Text Messages**

Hadas Reich; Daniel Pique; Matthew Anderson, MD MS; Blanca Samayoa, QB

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Background: Treatment adherence is an important goal in HIV care both because it benefits individual patients and because suppression of the viral load reduces the risk of HIV transmission. Weekly text messages have been shown to be effective in improving the number of patients with viral load control.

Setting: The Clinica Familiar Luis Angel Garcia (CFLAG) is an HIV specialty clinic located in Guatemala City and associated with the Hospital General San Juan de Dios. CFLAG has a cohort of 2,401 patients receiving HIV treatment.

Methods: This will be an RCT. Eligibility criteria: Adult patients on anti-retroviral medications. Patients must be either newly enrolled or have VL over 40. They must have a cell phone with texting capability. They must be willing to get texts and able to read/interpret them.

Intervention: The intervention group will get a weekly text message with a neutral meaning: 'This is your reminder.' The control group will get one text message at the beginning and then no further texts.

Measures: The main outcome variable is viral load suppression to less than 40. Secondary outcomes are: Change in CD4 counts, Opportunistic infections, patient self-reported adherence, attendance at clinic appointments, patient experiences/satisfaction, pharmacy data. All but these last two items are collected routinely every three months.

Status: This study is awaiting approval by the Research Committee at the Hospital General San Juan de Dios.

Next Steps: If this intervention is successful it might support future research in the use of cell phones: Would patient benefit from having phone contact with the clinic? What is the best type of message and how frequent? Can texting be used for outreach to at-risk patients?

## Community Health

### Presentation #14

#### **Laundromats, Salons, & Auto Shops 'Go Nuts': Unexpected Food Sources Could Support Healthier Diets in Urban Neighborhoods**

Sean Lucan, MD MPH MS; Don Hum Yoon; Luisa Sperry; Jason Seitchick; Andrew Maroko

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Context: Family physicians manage obesity and diet-related diseases. Physicians' management might not overcome the influence of unhealthy food environments in patients' neighborhoods. Studies of neighborhood food environments have focused mostly on accessibility to food stores and restaurants, not on the specific food-and-beverage items they offer nor on other store-front businesses.

OBJECTIVE: To assess all store-front businesses and their food-and-beverage offerings in neighborhoods having different accessibility/transportation characteristics. Design: Cross-sectional. Setting: 14 neighborhoods (census tracts) in each of two regions of Bronx, NY having different retail densities (Region A>B) and rates of vehicle ownership (Region B>A).

'Participants': Store-front businesses. Outcome Measures: For all store-front businesses in the 28 census tracts, researchers assessed for 'healthier foods' (fresh produce, whole grains, unsweetened nuts), 'less-healthy foods' (e.g., refined sweets, salty snacks),

'healthier beverages' (water, milk), and 'less-healthy beverages' (e.g., sugary drinks, alcohol).

Preliminary Results: Based on ~80% of expected data (>2,000 observations), Region A had more than twice as many businesses as Region B. In both regions, 'food businesses' (e.g., supermarkets, restaurants) were half as numerous as 'other businesses' (e.g., laundromats, beauty salons, automobile shops). About 25% of 'other businesses' offered food-or-beverage items in both regions. 'Other businesses' were more likely to offer less-healthy items overall, but offered healthier items more frequently in Region A vs. B ( $p=0.007$ ). Specifically, 'other businesses' more often offered nuts ( $p=0.014$ ) and whole grains ( $p=0.042$ ) in Region A vs. B. Among 'food businesses', only bodegas (small grocers) offered healthier items more frequently in Region A vs. B ( $p=0.028$ ). Conclusions: Neighborhood food environments include businesses beyond just intuitive food stores and restaurants. Food-and-beverage items (including some healthier items), are available through other kinds of businesses, particularly in neighborhoods with lower vehicle ownership and greater retail density. Family physicians might support greater healthier-over-less-healthy food-and-beverage availability in such neighborhoods.

## Presentation #15

### Home Care: Discharge Disposition for the Older Adult after Elective Joint Replacement Surgery

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Discharging patients to home after elective joint replacement surgery (EJRS) has proven to provide efficient clinical outcomes, as well as cost savings. Methods: Montefiore Medical Center, Bronx, NY, is a large academic medical center, serving a socioeconomically diverse population of patients. A collaboration between the Joint Replacement Center and the Home Care agency (MHC) at Montefiore was initiated in 2012 to increase the number of patients discharged to home for rehabilitation after EJRS. The goal of the collaboration was to decrease hospital length of stay, improve pre-operative teaching, and reduce utilization of sub acute (SNF) services, while improving clinical outcomes. MHC implemented intensive clinical services on day one post hospital discharge which included nursing, physical therapy, and home health aide. Week 1, all services are on a daily basis. During weeks 2 and 3, the frequencies of services were dependent on the surgeon's orders, patient progression, and patient choice. Results: In the year prior to the initiation of this program, of 621 patients undergoing EJRS, 31% (195/621) were discharged to MHC and 68% (426/ 621) were discharged to a SNF. In 2012, when the program was initiated, of 554 patients undergoing EJRS 40% (219/554) were discharged to MHC and 60% (354) discharged to SNF. In 2013, 51% (410/799) were discharged to MHC, and 49% (389/799) were discharged to SNF. Before the program was initiated, the average hospital length of stay (LOS) for patients discharged to MHC was 4.1 +/- 2.3 days. After initiation, the LOS was 3.2 +/- 1.1 days ( $p < 0.001$ ). The LOS for patients discharged to SNF before the program was 4.0 +/- 2.2 days, as compared to 3.6 +/- 2.6 days ( $p < 0.001$ ) after program initiation. The mean age of patients on program is 60 years of age. Conclusion: A strong collaboration between a home health care agency and an academic orthopedic practice can have a significant impact on the discharge disposition after EJRS. Patients achieved excellent functional outcomes, when discharged directly to an accelerated home care rehabilitation program. We were able to substantially increase the number of patients discharged home while simultaneously decreasing the average LOS. On the basis of our findings, we recommend the use of a home-based

rehabilitation protocol following elective primary total hip or knee replacement as an important intervention for patients to achieve optimal functional outcomes in an efficient time frame.

### **Presentation #16**

#### **'A Place at the Table:' Community Members' Experiences and Expectations for Academic-Community Partnerships in HIV/AIDS Research**

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**Introduction:** Community advisory boards (CABs) are one mechanism through which academic-community partnerships are formed, but current research about CAB members' opinions on barriers to collaborations with academics is limited. This qualitative study examined CAB members' experiences in working with academic researchers in the field of HIV/AIDS. **Methods:** We conducted 10 semi-structured one-on-one interviews with individuals serving on a CAB for HIV-related research. Participating CAB members were leaders of HIV/AIDS community organizations in Bronx, NY. Interview questions focused on participants' experiences with academic research, trust in these relationships, and best practices for collaboration. Interviews were professionally transcribed and data were analyzed using a grounded theory approach. Transcript data were coded by two independent researchers using NVivo 10 software and analyzed in an iterative process to identify emergent themes. **Results:** CAB members described positive aspects of inclusion on a CAB, including improved access to information about current HIV topics and the opportunity to help shape HIV research in their communities. However, CAB members also described negative previous interactions with researchers, and a lack of trust in researchers themselves or in the process of conducting research with academic institutions. A major reason for distrust was that power was perceived as unequal, often resulting in miscommunications that led to lasting negative impressions. In addition, CAB members felt that expectations for collaboration were not clearly established. They also shared suggestions for improving the collaborative process, including outlining expectations from the outset of the partnership and holding CAB meetings in the community rather than at the academic center. **Conclusions:** We identified complex interpersonal issues in relationships between CAB members and academic partners, particularly around trust and power-sharing. Our findings suggest that academic-community collaborations could be enhanced by improving transparency, addressing issues of distrust from previous negative experiences, and ensuring equitable power-sharing among researchers and community members.

### **Presentation #17**

#### **Bridging the Gap to Pre-K through the Medical Home**

Hildred Machuca, DO, FAAP; Arielle Mishkin; Phoebe Noe; Jenny Ajl; Barbara Hackley, CNM; Jo Applebaum, MPH; Alan Shapiro MD, FAAP

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**Background:** Access to an enriched supportive education for young children is crucial, particularly among low-income, underserved populations. Despite the recent expansion of Pre-K, competition for limited slots remains fierce. Further, the application process is complex, varies across programs (school- and community-based), and families must meet specific deadlines. Acknowledging these barriers, the South Bronx Health Center (SBHC), a federally-qualified health center located in the poorest congressional district in the US, implemented an outreach program to help families apply. **Objective:** To facilitate Pre-

K enrollment for SBHC patients by increasing parental awareness of the application process, timeline, and available resources. **Intervention:** All current SBHC patients turning 4 years of age in 2014 were eligible (N=211). Staff sent letters to parents of all eligible children describing both the school- and community-based Pre-K application process, along with a directory of programs in the Bronx. Staff phoned families 2 weeks before the application became available, and once during the open application window. Staff offered interested parents resources and information, including on-site assistance with application-related questions. Families were contacted 2 months after the application deadline to assess final acceptance status. **Results:** Of 211 eligible families, 118 were successfully contacted. Staff provided further information and resources about Pre-K programs to all families. Of those contacted, 60.1% (n=71) reported their child was not enrolled in a Pre-K or Head Start program. Notably, 52% (n=59) reported no prior knowledge of Pre-K programs or the enrollment process. Among the 71 children not enrolled in a pre-school program, parents of 53.5% (n=38) applied to Pre-K and 40.8% (n=29) were accepted. Those not accepted were waitlisted. **Implications:** Although New York City launched an ambitious expansion of Pre-K, substantial barriers to enrollment persist. Interventions that address parental knowledge and direct linkage to resources are needed, as well as a more streamlined application process.

## Presentation #18

### **The Long-Term Impact of Group Prenatal and Well-Baby Care**

Barbara Hackley, CNM; Anna K. Savage, MPH, CHES; Martiza Franqui, MPH Candidate; Hildred Machuca, DO, FAAP; Sandra Arevalo, RD, CDE, MPH; Mia Stange; Alan Shapiro MD, FAAP

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**Background:** The South Bronx Health Center (SBHC) offers group prenatal and well-baby care as an alternative to traditional one-on-one care. This interactive format provides greater social support and fosters health-promoting behaviors. Prior research shows increased knowledge, lower preterm delivery rates, and higher breastfeeding rates among group participants compared to those receiving traditional care. No study to our knowledge has explored long-term benefits of group care. **Objective:** The purpose of this study was to elicit women's perceptions of the advantages and disadvantages of group care, whether group care met their needs, and any long-term benefits in terms of knowledge, skills, behaviors, and social support. Group care emphasizes healthy nutrition for mothers and their children, stress management, and building healthy relationships. **Design:** In this formative qualitative descriptive study, a convenience sample of women who completed group care at SBHC were interviewed by phone using a semi-structured interview guide. **Participants:** Between 2008-2012, SBHC offered 19 prenatal and 12 well-baby groups. Participants from 50% of prenatal and well-baby groups were represented. 53% (n=9) completed both groups, 35% (n=6) prenatal only and 12% (n=2) well baby only. **Results :** Group care appears to have a lasting impact for most participants. Key themes indicated that: 1) women were highly satisfied with group care; 2) group laid the foundation for sustained changes in health behaviors, in that women continued using skills acquired in group relating to better nutrition and managing stress; 3) group improved relationships and communication with women's children and families, and 4) group helped build long-lasting connections between women. Many women remain friends with at least one group member. **Conclusions:** Despite 'graduating' from group on average 2.5 years prior to the interview, many women reported that the group experience had a profound impact on their lives. Group was a welcome source of information and support for low-income women residing in a high-stress community.



**Presentation #19****ENGAGE-NYC: A Social Media Based Linkage-to-Care Intervention for Men Who Have Sex with Men and Transgender Populations in New York City**

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Background: Men who have sex with men (MSM) and Transgender (TG) individuals, especially those who are grouped as racial/ethnic minorities, are disproportionately affected by HIV. Health disparities in these groups are likely exacerbated by a decreased access to culturally sensitive and non-judgmental care. Objective: To increase access to comprehensive primary care health services and HIV treatment for MSM and TG populations in the Bronx and NYC. Setting: Multiple social media and mobile dating applications frequently used by MSM and TG communities in the Bronx and NYC. Intervention: Using a community based participatory approach, we are partnering with MSM peer leaders in the Bronx and a social media marketing firm to develop ENGAGE-NYC. We first conducted 2 focus groups (recruited MSM/TG participants via Facebook) to identify potential barriers of linkage-to-care for this population, and obtain input into intervention design and delivery. The intervention, currently being created, consists of online campaigns using targeted advertisements on the multiple social media platforms to disseminate messages (text, graphics, short videos) that target potential barriers to and facilitators of linkage-to-care (e.g. stigma, cost). The intervention will be rolled-out in four waves over the next 8 months. Primary Evaluation Metrics: Number of individuals exposed to our online campaigns, number clicking through to our website, number contacting us for information/appointments, the number retaining appointments, and the number of HIV positive individuals enrolled into care. Conclusion: ENGAGE-NYC is an innovative and novel intervention that has the potential to reach thousands of previously difficult to reach and engage MSM and TG individuals in the Bronx and NYC and help impact health disparities by reducing barriers and facilitating access to care.

**Health Systems and Research Capacity****Presentation #20****ICTR Clinical Research Center**

Gail Glenn, RN, M.Ed.; Minka Chikolareva, RN

*Contact: gail.glenn@einstein.yu.edu***Presentation #21****PCMH Implementation and Primary Care Provider and Staff Burnout: A Process Analysis**

M. Diane McKee, MD, MS; Diana Carvajal, MD, MPH; Elizabeth Alt, MD, MPH; Claudia Lechuga, MS; Stephanie Neves, BS, MA; Arthur Blank, PhD

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Context: The Patient Centered Medical Home (PCMH) is critical to primary care improvement. PCMH implementation can directly impact provider and staff burnout. As part of implementation at two primary care sites in the Bronx, various initiatives were undertaken. These efforts were evaluated for impact on provider and staff burnout levels. Objective: Assess all-staff burnout before and after PCMH

implementation. **Methods:** Design: cross-sectional, pre- and post. **Participants and Setting:** providers and ancillary staff at 2 outpatient primary care sites in the Bronx. Participants were surveyed about their burnout levels via self-administered questionnaires at baseline and one year after PCMH implementation. **Measurements:** 1) Number of new workflows; 2) Staff-to-Provider ratios; 3) All-Staff burnout: 15-item Burnout Self Report scale assessing frequency of employee burnout; items scored on a 5-point scale ranging from never - everyday. Scoring range: little/no sign of burnout (0-32) - very severe risk of burnout (60-75). **Main Outcomes:** Change in: 1) staff-to-provider ratios; and 2) all-staff burnout from baseline to one year after PCMH implementation. **Results:** Response rates at site 1 were 92% (68/74) at baseline and 80% (64/80) at 1 year; for site 2, 65% (69/106) and 85% (88/106), respectively. Site 1 introduced 16 new workflows; site 2: 30 new workflows. Site 1 staff-to-provider ratio was 2.0 at baseline, and 2.7 at 1 year; site 2: 5.0 and 3.8, respectively. Planned staffing ratios were 3.0 for site 1, and 5.0 for site 2. Site 1 mean burnout score at baseline was 34.2, and 33.4 at 1 year ( $p = .74$ ); site 2: 40.9 and 42.0, respectively ( $p = .56$ ). **Preliminary Conclusions:** While PCMH implementation was expected to improve all-staff experiences, this was not the case for burnout levels. We hypothesize the lack of improvement at this phase of implementation was due to an increase in responsibilities (workflows) and workload without a matched increase in staffing ratios, and concurrent demands for meaningful use documentation.

## Presentation #22

### Effect of an Electronic Alert on Treatment of Soft Skin Tissue Infections

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**Objective:** Our objective was to evaluate the ability of an electronic alert to influence provider practice in treatment of skin and soft tissue infections (SSTI). **Materials and Methods:** This was a prospective intervention/control study conducted at sixteen Federally Qualified Community Health Centers in Manhattan, the Bronx and the Mid-Hudson Valley between 2010 and 2011. Participants studied were patients with SSTI infections. Intervention patients were defined by ICD-9 codes for SSTI. A best-practice alert (BPA) that included an order-set with decision support was programmed to appear when these codes were entered in the electronic health record (EHR). Controls were patients who had other SSTI ICD-9 codes where the BPA was not programmed to fire. Rate of culture taken in patients with SSTI was compared between the intervention and control patients. Data were collected from the EHR, EPIC. **Results:** Intervention and control groups were similar in age and gender. Cultures were taken among 13.5% of the intervention group and 5.4% of the control group ( $p < 0.0001$ ). A logistic regression analysis controlling for age, gender, pulse, BMI, and fever showed that the odds of the intervention group having a culture taken was 2.6 times that of the control group (95% CI: 1.9, 3.5). **Discussion:** Cultures were taken more frequently in SSTI patients whose clinicians were exposed to the BPA. **Conclusions:** Our findings suggest that in the context of skin and soft tissue infections presenting in primary care settings, situation dependent decision support alerts are capable of significantly altering health care provider clinical behavior beyond that produced by published clinical guidelines alone.

**Presentation #23****Relationship of Job Satisfaction and Team Culture to Primary Care Provider and Staff Burnout**

Claudia Lechuga, MS; Jason Fletcher, PhD; Stephanie Neves, MA; Paul Meissner, MSPH; Arthur Blank, PhD; M. Diane McKee, MD MS;

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Context: Job satisfaction and burnout are key determinants of primary care function and improvement. Development of stronger primary care teams may mitigate burnout. Objective: Assess the relationship of staff and physician burnout, team culture and job satisfaction at urban practices participating in a network-wide patient-centered medical home (PCMH) implementation. Methods: Design: cross-sectional, anonymous survey. Participants and Setting: clinicians and staff at 15 outpatient primary care sites in the Bronx serving primarily minority patients. Measurements: 1) Associate Satisfaction: 6-item survey assessing perceptions of work environment; 2) Maslach Burnout Inventory: 16-item survey assessing employee burnout across three subcategories (exhaustion, cynicism, and professional efficacy); 3) Team Culture: 9-item survey assessing quality of task-related interactions. Main Outcomes: Relationship of job satisfaction to professional efficacy, exhaustion and cynicism and to team culture. Results: Response rates among the sites ranged from 33%-96% of all-staff. All-staff at-risk for burnout varied for low efficacy (18%), cynicism (27.4%) and exhaustion (45.6%). Team culture scale scores by practice ranged from 5.4 to 8.7. Better team culture scores were reported by those at low-risk for exhaustion (7.05 vs 5.73;  $p < 0.001$ ). Being at-risk for exhaustion was associated with lower levels of job satisfaction (ie, having unclear job responsibilities [68.6% vs 39.7%], lack of decision-making involvement [59.5% vs 33.1%], and ineffective communication [55.3% vs 36.8%] ( $p < 0.001$ ). Staff endorsing a climate of trust and effective communication in the workplace reported the strongest team culture (7.18 and 7.31 respectively). Low-risk of exhaustion was most related to belief that skills are fully utilized among attending physicians (41.4% vs 76.5%) climate of trust for nursing (22.4% vs 61.6%) and clear roles for non-professional staff (31.1% vs 72.2%) ( $p < 0.001$ ). Conclusions: Strong association between job satisfaction, team culture and employee burnout suggests that PCMH implementation should explicitly address development of stronger teams to improve satisfaction and potentially mitigate burnout.

**Presentation #24****Quantifying the Impact of the EMR and PCMH Transformation on Physician Workload and Morale**

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Context: Practices becoming patient-centered medical homes have reported initial increases in physician workload and reduced morale. Primary care 'sessions' continue to be fully scheduled with relatively brief patient visits, but--enabled by the electronic medical record (EMR)--an increasing volume of 'non-visit work' occurs before, after, and between visits and is not captured by traditional measures of 'productivity'. In the Bronx, as Montefiore Medical Center's primary care network undertook its PCMH transformation, researchers documented high burnout risk, particularly among physicians in residency training practices. Objective: To quantify the clinical workload of primary care physicians--including visit and non-visit work--in teaching and non-teaching settings. Setting: Five primary care practices

within the Montefiore Medical Group, all documenting care on Centricity EMR. Participants: Attending and resident family physicians, internists, and pediatricians. Instrument/Intervention: Time physicians spent logged onto the electronic medical record (EMR) was used as a measure of total time devoted to direct patient care and precepting. For two months, physicians' EMR logon hours were audited electronically and were compared to their scheduled patient care and precepting hours. Results: On average, for teaching family physicians, internists, and pediatricians, every 4 hours of scheduled clinical time generated an additional 2.4, 2.0, and 0.8 hours of EMR 'homework', respectively. About 40% of this additional work was completed during non-work hours (evenings and weekends), and about 60% during time allocated to other work activities (such as didactic teaching and research). Conclusions: By making the work of primary care portable, the EMR has enabled this work to extend beyond the clinic walls and conventional work hours. Using EMR time stamp data, this expansion of the primary care workload can be measured and analyzed. The burden of 'non-visit work' is likely to be a significant factor in the high risk of burnout documented among primary care physicians. This risk may be mitigated by creating and training multidisciplinary teams that can optimally share the complex work of primary care, allowing all to work closer to 'top of license.'

## Presentation #25

### **Development of a Consent Form for use with a Universal Biobank**

Claudia Lechuga, MS; Karen Gallinari, Esq; Daniel Stein, MD; Brian Currie, MD MPH

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Montefiore Medical Center and Albert Einstein College of Medicine are committed to bring cutting edge advances in science and medicine to the Bronx community. The medical discoveries of tomorrow are likely to allow for personalized medicine based on biological traits of individuals. Research to further the development of personalized medicine requires the availability of and access to biological material of large numbers of people from diverse races and ethnicities. The rich diversity of cultures in the Bronx provides the opportunity to make major contributions to research necessary to advance personalized medicine and other improvements in the prevention, diagnosis and treatment of disease. Collections of human specimens stored for research are called biobanks or biorepositories. Montefiore Medical Center and Albert Einstein College of Medicine have a joint biobank containing specimens collected from patients who chose to participate in a disease specific study. One of our strategies to ensure our Bronx community has access to and the opportunity to participate in the latest advances in medicine is to increase the number and diversity of patient specimens available for cutting edge research. As part of our efforts to have our research potential be representative of the population we serve, the Montefiore Medical Center and Albert Einstein College of Medicine will begin a new initiative to invite patients to participate in research by contributing their left over blood, tissue or urine specimens to our joint research biobank. This new initiative will utilize an IRB and Community Board approved informed consent form that requests permission to store and use leftover patient specimens for research, which will be designed in the future to find new ways to prevent, diagnose and treat disease.

**Presentation #26****BraveNet: An Integrative Medicine Practice-Based Research Network**

Claudia Lechuga, MS; Benjamin Kligler, MD MPH; M. Diane McKee, MD MS

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Known for its insight and the ability to find the 'tipping points' that help transform culture, in 2007 the Bravewell Collaborative embarked on a new venture to challenge the way medical community thinks about health and healing through the creation of the nation's first practice-based research network in integrative medicine. Under the guidance of the Duke Clinical Research Institute, which served as the Coordinating Center, BraveNet spearheaded research in revealing what types of patients seek services at integrative medicine clinics and what problems these patients wish to solve, on integrative medicine treatments and approaches to chronic pain, and characteristics of cancer patients presenting to integrative medicine practices, among others. In a new iteration beginning January 2015, Albert Einstein College of Medicine, Department of Family and Social Medicine, under the direction of M. Diane McKee and Ben Kligler, will serve as the Coordinating Center for BraveNet and continue to lead the network of 14 leading integrative medicine centers around the US collaborating in projects to increase the knowledge and evidence-based practice of integrative medicine.

**Mental Health****Presentation #27****Collaborative Care to Reduce Depression and Increase Cancer Screening Among Low-Income Urban Women Project - Prevention Care Manager 3 (PCM 3) Project: Patient Recruitment: Challenges and Innovations at Morris Heights Health Center (MHHC)**

Alison Maling, LCSW; Marjorie Diaz, BA; Annette Cardenas, BS

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This goal of this Randomized Controlled Trial (RCT) is to determine whether a collaborative care intervention that addresses depression and cancer screening needs simultaneously among women ages 50-64 is more effective at improving cancer screening and patient-reported outcomes for women with depression than an existing evidence-based cancer screening intervention alone. MHHC and two other Bronx Federally Qualified Health Centers will recruit approximately 756 (n= 252 per site) women ages 50-64 who screen positive for depression and who have not completed recommended cervical, breast, and/or colorectal cancer screenings. Goals and Objectives: This poster will showcase both the challenges faced and innovations implemented since the start of recruitment. Challenges include well established cancer screening practices at MHHC which contribute to a low population pool, competing priorities, and insufficient time for recruitment and intervention. Methods: Prevention Care Managers use a combination of strategies to identify and recruit prospective participants, including previous day medical record review, outreach across all MHHC satellite sites, and efficient use of the EMR system. A multi-disciplinary project team was formed and the team meets weekly to review process data, trouble shoot and determine best practices. Results: Recruitment for the project began on January 29, 2014. Over a 6-month period MHHC's Prevention Care Managers (PCMs) screened a total of 332 patients, of which 82 have been enrolled. This represents 58 percent of the targeted recruitment goal. The PCMs have gradually improved performance by becoming more effective and efficient. They have fortified relationships with the medical staff and have become more familiar with the flow of patient operations at

satellite centers. The new recruitment strategies facilitate project implementation by allowing for more successful patient enrollment, as well as retention. Conclusions: The recruitment innovations implemented at Morris Heights Health Center have increased the patient population pool and have allowed the team to expand the recruitment activities to include all MHHC clinical sites. These innovations may serve as a framework for other sites involved in the project and for future projects which seek to recruit patients from primary care practices.

### Presentation #28

#### **Integrated primary care and behavioral Health -Computerized cognitive behavioral therapy program**

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Context- CMO and MMG working together to integrate effective and coordinated behavioral health services in primary care. As part of the NYS Hospital Medical Home Demonstration project, NYSDOH identified Montefiore as an early adopter for integration strategies that will adopt evidence based practices as part of routine care. NYSDOH encouraged Montefiore to try using I-CBT, a computerized platform that delivers cognitive behavioral therapy through an internet based program. Working with MMG and CMO social workers and behavioral health managers, appropriate patients with depression were selected to receive treatment at their own convenience in addition to their standard CBT treatment. 'Beating the Blues(BTB), a computerized cognitive behavioral therapy program (ICBT) has been shown to an effective tool in the treatment of mild and moderate depression and mixed anxiety/depression conditions at a reduced cost. It will further enhance our already robust medical and behavioral health integration at the CMO and MMG. Primary users of this program were site social workers and behavioral health managers. This approach will enhance access to care and may remove some barriers which often keep patients from receiving behavioral care (stigma, privacy). The addition of this tool to the current integrated model already in place at some MMG sites (through the CMO IMB team or with MMG local integrated models) may result in improved outcomes for a subset of patients.

### Presentation #29

#### **Integrating Routine Mental Health Screening into Annual Well Child Visits**

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Context: Healthy People 2020 and the American Academy of Pediatrics have mandated mental health screening of school age children. The experience of the Bronx Ongoing Pediatric Screening in the Medical Home initiative supports the finding that the implementation of routine mental health screening requires multidisciplinary teamwork and provider engagement. This can be facilitated at sites with and without trainees by designing a program that cultivates the unique talents of representatives from each element of the team. Collaboration between champions in the administrative, nursing and physician cadres led to the development of sustainable change. Instruments/Intervention: The goal of annual universal screening of all children between the ages of 4 to 18 with the validated Pediatric Symptom Checklist-17 (PSC-17) item version was a novel intervention for these 11 practices that provide health care services to multi-ethnic, lower socioeconomic families in the Bronx. All of the practices had no prior experience with

large-scale mental health screening in the school age population. Results: Starting from a baseline of 0% in October 2012, the results of 87% with the PSC-17 and 92% with the youth version by the end of May 2014 were achieved through small tests of change, with active review and revision to meet the needs of each clinical team. Conclusion: Improvement of screening rates once a regimen is established involves continuous reinforcement of rationale and processes. Future research will examine the disposition and plans that were implemented for individuals with positive screen results and the interface between positive screen results and chronic illness in the school-age child.

### Presentation #30

#### **Monday Blues: An Effective Depression Reassessment and Outreach Process**

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Urban Health Plan, Inc. (UHP) is a network FQHCs providing comprehensive and affordable primary and specialty health care services to the South Bronx and Corona Queens, NYC. UHP successfully improved the treatment of adult depression by applying an interdisciplinary team based approach utilizing Ed Wagner's evidence based Chronic Care Model, The Model for Improvement, and the Institute for Health Care Improvement Learning Model. The team members at Plaza Del Sol Family Health Center (PDS) located in Queens implemented an innovative telephone outreach process (Monday Blues) to increase reassessments and follow up on adult patients identified as depressed using the Patient Health Questionnaire 9 (PHQ-9). Monday Blues is held one Monday evening per month when a team of case managers, a social worker and a medical provider stay after regular working hours to conduct telephone outreach.

## Reproductive Health

### Presentation #31

#### **Reproductive Coercion And Ambivalence Towards Pregnancy: Under-recognized Factors In Unintended Pregnancy In Primary Care Populations?**

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Each team member is assigned a list of patients based on last PHQ-9 score and any previous reports of suicidal ideation. In addition to conducting depression reassessment using the PHQ-9, each team member provides depression education, behavioral health appointments, social services assistance, and will transfer any questions about antidepressants to the on-call medical provider.

### Presentation #32

#### **Uptake and Acceptability of Simplified Follow-up After Medical Abortion**

Ariana Bennett, MPH; Marji Gold, MD; Tara Stein, MD MPH; Dana Schonberg, MD MPH; Lin-Fan Wang, MD MPH

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Results: As of July 2014, 61% of adult patients (N=5,801) have been screened for depression at Plaza Del Sol Family Health Center. Thirty-nine percent (N=41) of clinically depressed patients (PHQ >=10) were rescreened within 4-8 weeks.

### Presentation #33

#### **How patients choose and experience early abortion care in the family medicine setting**

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**Background:** Prior studies have demonstrated that patients are generally comfortable with the option of receiving early abortion care in the family medicine setting, and some may even prefer it to other settings. In addition, patients who received early abortion care in the family medicine setting have reported satisfaction with their experience. However, there are few in-depth qualitative studies exploring patient experiences of abortion care in the family medicine setting. **Objectives:** To determine why and how patients select a family medicine setting for early abortion care, to assess their experience in the family medicine setting, and to compare it to prior abortion experiences in other settings when applicable. **Methods:** Semi-structured interviews with women who received early abortion care (medication or aspiration) at a Family Medicine continuity clinic in a diverse urban low-income setting. Thirteen interviews have been completed, with a target of fifteen in total. Transcripts analyzed using NVivo and a modified grounded theory method. **Results:** Based upon interview data thus far, respondents cite several key factors that contributed to their decision to receive abortion care in a family medicine setting. These included pre-existing connection with their medical provider, convenience, comfort and familiarity with the clinic and anticipated increased privacy. Respondents state that these and other factors contributed to high levels of satisfaction with care and would recommend this setting to others.

### Presentation #34

#### **Urban Adolescents and Young Adults' Decision Process around using Intrauterine Contraception**

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**Objective:** The intrauterine contraceptive device is one of the most effective contraceptive methods, but utilization rates are low, especially among adolescents. There is limited data on adolescent contraception choice and IUDs. The objective of this study is to better understand the factors guiding adolescents' choice to use an IUD. **Study design:** Qualitative semi structured interviews were conducted with 27 adolescents aged 16-25, on the day of their scheduled IUD insertion. Participants were recruited at the Children's Hospital at Montefiore's Adolescent Clinic after they checked in for their appointment and were waiting to see the clinician. Interviews were recorded and later transcribed. A modified grounded theory analysis approach was used to analyze the transcripts. Themes were identified by two independent researchers through line-by-line analysis of interview transcripts. **Results:** The factors that emerged from our data as most salient in shaping respondents' choice to start using an IUD now include: IUD device-specific, health care provider, social network, and individual factors. The majority of the participants are attracted by the ease of a user-independent method, the high effectiveness, longevity of use, as well as knowing there is an option to remove the device prior to device expiration. Many



participants say that the health care provider is the most reliable source from which to get contraception information, and identified their health care provider as the most influential person affecting their choice of an IUD. Of all the groups in their social network, mothers appear to play the biggest role in the decision to get an IUD. Many respondents select an IUD after experiencing negative side effects or adherence challenges with other methods. Conclusions: Adolescents consider a number of factors during their decision making process when choosing an IUD. Addressing these factors during contraceptive counseling with adolescents may lead to improved adolescent centered IUD counseling, and increased IUD-uptake in the adolescent population.

### Presentation #35

#### **Managing Early Pregnancy Loss in Primary Care: Findings from Mixed-Method Research with Family Physicians Trained in Uterine Aspiration**

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Background: While research shows that miscarriage can be safely managed in primary care settings, many women continue to use the Emergency Room (ER) for evaluation and treatment of early pregnancy bleeding. To understand the factors affecting miscarriage care in primary care settings we conducted a mixed-method study with family physicians (FPs) trained in all three early pregnancy loss treatment options during residency. Methods: In-depth interviews were conducted with 15 FPs and analyzed using Dedoose software. Qualitative research findings informed development of a web-based survey which was disseminated to over 500 FPs trained in managing early pregnancy loss. Results: Data analysis is currently underway. Preliminary findings from both the qualitative and quantitative studies (n= 142) include: Expectant management (85.2%) was the most likely treatment to be provided, followed by medication management (58.5%) and uterine aspiration (15.5%). Onsite or easy access to ultrasounds facilitates medication and uterine aspiration treatment (44.7% and 63.6% respectively). Strong clinical leadership existed in sites providing all three treatment options (qualitative interviews). Barriers to providing uterine aspiration include: need for more/refresher training (36.7%), equipment, supplies and adequate space (36.7%); logistical considerations (35%); and that the practice sends patients to an ob/gyn for management (33.3%). Conclusions: The preliminary findings of our research indicates that transitioning miscarriage care from the ER to primary care settings requires strengthening FP training in all three treatment options and addressing logistical requirements in clinical settings.

### Presentation #36

#### **Levonorgestrel IUD as Possible Emergency Contraception?**

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Context/Design: In the last 10 years, post-coital or emergency contraception (EC) has become a new strategy for preventing pregnancy. Unfortunately, the pills for EC are not highly effective and the copper IUD is often not a woman's preferred IUD. Thus, we conducted a retrospective chart review at our clinic over 5.5 years to assess whether Levonorgestrel (LNG/Mirena) IUD might work as EC. Post-abortion insertions were excluded. Results: A total of 3075 LNG-IUDs were inserted, 2668 were not inserted post-abortion. Of these 2668, 88 patients were given Plan B for self-reported history of unprotected intercourse in the three days prior to insertion of the LNG-IUD. 32 of these 88 had an LMP between 11-19

days prior to insertion. Of these 32, 22 had a BMI  $\leq 25$  and/or weight  $>155$ lb, placing them at high risk for Plan B failure (Group 1). 499 patients (Group 2) had their insertions during days 11-19 but did not get Plan B, because they did not admit to unprotected sex since LMP. None in these groups became pregnant. Two positive pregnancy tests were found in the 2668. On review, they were not LNG-IUD as EC failures. One became pregnant two months after the LNG-IUD insertion, and the other pregnancy dated to show that she had likely become pregnant in the week prior to the IUD insertion rather than in the week of the IUD insertion (when we hypothesize that it may work as EC). Conclusions: In two groups of women with LNG-IUD insertion done at a high-risk time in their menstrual cycle where one got Plan B for reported unprotected sex and the other did not, none became pregnant. Thus, we postulate that there may be mechanisms of action whereby the LNG-IUD works as emergency contraception. Further studies are needed.

### Presentation #37

#### **Overcoming Racial and Ethnic Disparities in Contraceptive Care**

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As family planning providers who work with underserved and minority populations, it is imperative that we understand the extensive history of discriminatory practices and the racial, ethnic and socio-cultural disparities that affect effective contraceptive use. Current statistics show that 83% of Black women at risk of unintended pregnancy currently use a contraceptive method in comparison to 91% of their Hispanic and White peers and 90% of Asian women. In order to better understand these disparities, we have focused on 'SANKOFA', a Ghanaian phrase that means 'Look back before you look forward.' The history of reproductive healthcare delivery in the United States is marred by its association with the eugenics movement. Being aware of the history behind the current distrust and misconceptions in contraceptive care helps us better understand the basis of our patients' concerns in regards to family planning interventions. In some cultures, this distrust and misconceptions have been passed from one generation to the next. Looking back teaches us what we must overcome to gain the trust of our patients going forward. Conscious and subconscious racial biases from both providers and patients have been widely identified as barriers of care. Successful family planning throughout the reproductive years includes achieving desired family size and providing the opportunity for individuals or couples to live the lives they want. Providers need a professional style that will maximize trust between patients and physicians to overcome racial disparities and thus allow for the practice of effective contraception.

## Resident Education

### Presentation #38

#### **Integrating Social Determinants of Health in Pediatric Resident Education: the IHELLP model**

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Background: Children are extremely vulnerable to the deleterious effects of the social and physical environment, with long-standing impacts on health. The majority of residents are not educated about

these consequences and are not trained in asking about the social determinants of health during patient encounters. The 'IHELLP' mnemonic was developed at Boston Children's Hospital to effectively screen patients for needs in the following areas- income/benefits, housing, education, literacy, legal status, and personal safety. Objectives: The objectives of this project are to 1) educate pediatric residents in the various social determinants of health that affect our patient population and 2) assess the impact of an educational intervention on pediatric resident documentation of social determinants of health in the electronic medical record. Methods: A quasi-experimental comparison study pre- and post-interventions was utilized. Eight second-year and third-year residents participated in this study. The initial intervention involved a 3 hour Powerpoint educational presentation covering basic knowledge and available resources for each component of the 'IHELLP' model. The second intervention included posting of visual reminders in clinic regarding 'IHELLP' and availability of a resource handout for distribution to patients depending on need. A chart review of all well child visits seen by resident participants was completed at baseline, between intervention #1 and #2, and after intervention #2 using a 30-item checklist developed based off of 'IHELLP.' Results: Data collection is ongoing. A total of 363 charts will be reviewed: 103 at baseline, 143 at post-intervention #1, and 115 at post-intervention #2. Conclusions: Physicians should be educated on the importance of asking about social determinants of health to best optimize the health of patients as well as on the available resources in the local area. The 'IHELLP' model is an easy tool to use during patient encounters to review basic and legal needs.

## Screening and Health Promotion

### Presentation #39

#### **SAATHI (South Asians Acting Together for Health Improvement)**

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SAATHI, ('South Asians Acting Together for Health Improvement'--from a Bengali word that means 'community') is a community based diabetes prevention intervention for South Asian women immigrants living in New York City. Rates of obesity and diabetes are accelerating in the United States, especially among ethnic minority and immigrant groups. South Asian immigrants carry a higher disease burden than many other immigrant groups. Though weight control diabetes prevention interventions based on behavioral theory have been found highly effective in preventing diabetes, ethnic minority groups and immigrants face cultural and social barriers to accessing these interventions. SAATHI implemented a lifestyle modification and diabetes prevention intervention within the context of an innovative, participatory research framework that emphasizes the social and familial, as well as behavioral, causes of diabetes. Specific aims of the project included developing the intervention and conducting a preliminary test of efficacy. Patients with pre diabetes were recruited in primary care practices associated with SAPPHERE, a South Asian primary care research network in New York City. Participants were organized into 'action groups,' which functioned as support groups and learning communities. Each group met regularly for twelve months in waiting rooms or other practice spaces. Results of the pilot study are promising. Over 75% of patients were retained in the program. Average weight loss was 5.8%.

**Presentation #40****SAPNA ('South Asian Parents and Navigators Action for Child Oral Health')**

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Dental caries is a problem affecting the majority of poor and ethnic minority children in the United States. Nearly 30% of poor children between age two and four have untreated caries(1). South Asian immigrant children from India, Bangladesh, and Pakistan are at particularly high risk for dental caries with rates nearly double that of native populations. Structural factors, including social and economic deprivation and linguistic isolation, reduce access oral health care. Feeding practices such as prolonged bottle feeding and frequent use of bottle additives contribute to the epidemic of caries among young South Asian children. Other specific cultural factors, such as permissive childrearing practices and the disempowerment of mothers in traditional South Asian families, may also contribute to the problem. The SAPNA Feasibility Study (R34-DE-022282-0) randomized mother-child (9-18 months) dyads from two SAPPHIRE pediatric practices into Experimental (n=38) or Control (n=21) groups. This multi-level intervention pilot, based on empowerment theory, targeted three key oral health prevention behaviors: feeding practices, oral hygiene, and making an oral health visit. Enhanced Usual Care. All participants received an oral health education pamphlet in their language developed and piloted for this study, an ECC Talking Points counseling module from the pediatrician; and a referral list of available local providers. The experimental intervention consisted of: in-person MI counseling visits (n=2), follow up phone calls (n=4), and navigational support in making an oral health visit. Results: Among the 59 enrolled, 75% were retained at 6 month follow-up. 100% of those retained received the full-dose of intervention (2 visits + 4 phone calls) Though the study was not powered to detect treatment group differences in the target behaviors, a broad pattern of differences were found: oral health visit (73% intervention v. 14% controls  $p<.0001$ ); use tap water (100% intervention v. 85% controls); weekly teeth brushing frequency (6.8 intervention v. 3.8 controls); weekly sweets servings/increase (1.1 intervention v. 2.1 controls); weekly bottle use/decrease (11 intervention v. 3.1 controls  $p<.05$ ); weekly naptime bottles/change (no change in intervention v. +2.2 controls  $P<.05$ ) and weekly juice servings (+2.7 intervention v. +2.9 controls). Results provide preliminary evidence for the efficacy of our approach in altering even entrenched risk behaviors.

**Presentation #41****Sleep Health Education in Head Start**

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Context: Healthy child development requires sufficient, quality sleep. During the preschool years (ages 3-5) many children don't sleep enough, have behavioral sleep problems (i.e., getting/staying asleep), or sleep disordered breathing--all of which impair social-emotional and cognitive function, and increase obesity risk. Early childhood education (ECE) programs have untapped potential to promote sleep health. Objective: To explore this potential, we assessed parental and staff 'sleep health literacy' in Head Start, the nation's largest ECE program. Design: A convenience sample of n=196 parents, and n=63 staff members completed surveys on sleep-related knowledge, attitudes, and practices. Results: Parents achieved 50% correct on knowledge items. Between 10%-12% of children had sleep onset and awakening problems, and 33% did not sleep enough. There was a 'disconnect' between attitudes and practices; parents believe their children sleep enough (85%) and have healthy sleep habits (81%), but

unhealthy bedtime practices are common (50-70%). Parents reporting the least healthy bedtime practices, were the most motivated to improve and/or seek advice for them. Staff members believe that promoting healthy sleep is an appropriate Head Start function (89%), are comfortable discussing healthy sleep (87%), and affirm that children's sleep problems impact their work (77%). Conclusions: National literacy goals cite the need to 'embed accurate, accessible and actionable health information in all early childhood programs, such as Head Start.' Findings support promoting sleep health literacy in ECE programs.

#### **Presentation #42**

### **Barriers Preventing Primary Care Provider Referral of Obese Ethnic Minority Urban Adolescents to a Comprehensive Weight Management Program**

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Background: Severe obesity affects at least 6% of U.S. youth. Understanding barriers preventing referral to weight management programs will improve access to such services. We evaluated barriers preventing primary care provider (PCP) referral of obese and severely obese ethnic minority urban youth to a comprehensive adolescent weight management program (B'N Fit). Methods: Participants were 266 PCPs asked to complete a 20-item on-line survey assessing: awareness of 2007 Expert Committee obesity treatment recommendations; obesity treatment options; B'N Fit referral barriers. 87 (33%) opened survey and 83 (95%) answered some or all questions. 80% female; 65% white, 14% Black and 18% Asian; 19% <35 yrs, 49% 36-55yrs, 32% >55yrs; 18% identified as 'overweight', 80% 'normal weight.' Results: Adolescent obesity rates: 25-50% (53%); >50% (23%). 57% familiar with Expert Committee recommendations. Treatment options: websites (37%), education handouts (64%), nutritionist (54%), health educator (57%), B'N Fit (67%). 19% 'unaware,' 63% 'basic awareness,' 18% 'knowledgeable' about B'N Fit. B'N Fit referral likely or very likely (81%). 93% requested: email newsletter (67%), on-site visit (50%), website (46%), presentation (31%). Referral methods: phone number (52%), electronic medical record (38%), website (12%). Referral barriers: other treatment options (32%); unclear program success (26%); unclear insurance coverage (25%); lack of time (19%); no barriers (33%). Perceived patient barriers: time commitment (84%); not ready (70%); travel (57%); interested (48%). Additional comments reported: unclear referral process (8); program unavailability (14). Conclusion: Provision of accurate program information and referral process are necessary for PCPs seeking adolescent weight management service access for their patients who may already face many barriers to achieving weight loss.

#### **Presentation #43**

### **Collaborative Care to Reduce Depression and Increase Cancer Screening Among Low-Income Urban Women Project - Prevention Care Manager 3 (PCM 3) Project**

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Introduction: Colorectal cancer (CRC) is the second leading cause of preventable cancer-related deaths, and Blacks and Latinos are disproportionately affected. While CRC screening reduces cancer disparities, barriers exist at the system, clinician and patient levels. Prevention Care Management (PCM) has

increased CRC screening rates in eleven CHCs and four Medicaid Managed Care Organizations (MMCOs). Objective: Three consecutive randomized controlled trials (RCTs) tested whether PCM improves CRC screening among low-income, uninsured and Medicaid-insured women aged 50-64 in Community Health Centers (CHCs) and other primary care practices and Health Plans. We present here the spectrum of research from efficacy (PCM1), to effectiveness (PCMT), to dissemination and implementation (PCM2), to scale-up and sustainability (PCM3), and now examine the contribution to scale-up and sustainability of patient and community-based organization (CBO) stakeholder engagement. Methods: Health education/outreach staff, initially from one practice-based research network (PBRN) and four MMCOs, and now a second PBRN, three CHCs and two CBOs, provide structured telephone support in English, Spanish or Russian, to identify barriers and facilitators to receiving CRC screening. Women receive educational materials and were followed up using chart/EHR (PCM1/PCM3) and administrative/claims (PCMT/PCM2) data. Results: PCM addressed barriers at patient (competing priorities, concern about the test, lack of understanding about being asymptomatic); clinician (lack of clinician recommendation); and systems (difficulty making appointments and long waiting times for procedure) levels. CRC screening increased significantly in CHCs (OR=1.60,CI-) and Health Plans (OR=1.44,CI), as compared to Usual Care with no significant heterogeneity ( $I^2=54.9\%$ , $p=0.11$ ). Overall, PCM1/PCM2 effects are stronger for Spanish-speaking women (OR=1.92/1.81) versus English-speaking women (OR=1.38/1.13). Implementation Science Conclusions: PCM is robust and transferable, increases CRC screening, and can be disseminated and implemented successfully across a wide range of settings in underserved communities. Effective and sustainable PCM interventions address multi-level barriers, and should be integrated into primary care.

#### Presentation #44

### **BOPS in the Medical Home: An Innovative Quality Improvement Initiative**

M. Diane McKee, MD MS; Andrew Racine, MD PhD; Rahill Briggs, PhD; Marie Mann, MD MPH; Chris Kus, MD MPH; Arthur Blank, PhD; Paul Meissner MSPH

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Research Objective: To evaluate the implementation outcomes of a multi-site ambulatory network's comprehensive pediatric screening program in a diverse urban population. Study Design: Bronx Ongoing Pediatric Screening in the Medical Home (BOPS) is a Health Resources and Services Administration funded healthcare quality improvement initiative incorporating evidence-based medical home screening strategies across the pediatric lifespan in a consortium of 13 pediatric, school health, and family medicine practices in Bronx, NY. The BOPS implementation strategy combines a modified learning collaborative, real-time clinical data feedback to practitioners, quality improvement coaching and a pay-for-quality monetary incentive using multidisciplinary onsite teams consisting of a physician-champion and clerical and nursing staff representatives. The four-year project targets four screening domains: 1) newborn screening for genetic, metabolic and infectious diseases, 2) infant and toddler screening for developmental, behavioral and social/emotional disorders, 3) school age and adolescent mental health screening, and 4) screening of sexually active adolescents for sexually transmitted infections. Population Studied: The project population consists of the physicians, nurses, patient services representatives and their pediatric patients, 0-19 years of age at 13 health care centers in Bronx, NY, the poorest urban county in the United States. Principal Findings: Between March 2011 when the BOPS initiative launched and February 2013, the rate at which providers reviewed newborn screening results with the parents of newborns increased from 19% (SD=±0.32) to 86%(SD=±0.10) by 75 days of life. In

the same time period, provider documentation in the electronic medical record of adolescent sexual history increased from 60 % (SD=±0.25) to 90 % (SD=±0.09) at annual well child visits. At well visits, HIV screening for adolescents documented as sexually active increased from 52% (SD=±0.23) to 66%(SD=±0.29) and screening for gonorrhea and chlamydia from 62% (SD=±0.25) to 79%(SD=±0.24). In October 2012, BOPS sites began the roll out of routine mental health screening in early childhood through adolescence. By the end of November 2012, 7 of the 13 sites had introduced screening for developmental concerns at 12 months, 18 months and 24 months using the ASQ:3, MCHAT and ASQ:SE respectively and had increased from a baseline rate of 0% to 54-65% within six months. Concurrently, 4 sites introduced mental health screening using the PSC-17 for 4-11 year olds and the Y-PSC-17 for 12-18 year olds at annual well visits. Starting from a baseline of 0%, they have increased to 58% for the 4-11 year olds and 57% for the adolescents. Conclusions and Implications for Policy, Delivery or Practice: Troubling health disparities in the Bronx, NY and high variation in pediatric screening rates across multiple practices indicate the need for a systematized approach to this issue. In response to this challenge, the BOPS in the Medical Home collective demonstrates the positive impact of focused quality improvement (QI) efforts on screening rates in four pediatric domains and the efficacy of QI coaching, electronic medical record generated data feedback and multi-disciplinary teams as vehicles for improving the quality of pediatric health care.

#### Presentation #45

### **Improving Screening for Sexual Activity and STIs among Adolescents in Urban Primary Care: Results of a Learning Collaborative Approach to Quality Improvement**

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**Purpose** Sexually transmitted infections (STIs) remain a significant source of morbidity among adolescents. Many infections are asymptomatic, but pose significant risk for long-term sequelae. Urban communities, including the Bronx, are disproportionately affected. Primary care providers are well positioned to identify and treat STIs, yet many adolescents are not screened. Here we report changes in screening for sexual activity and STIs (N. Gonorrhea, C. Trachomatis [GC] and HIV) among youth age 13-19. **Methods** **Intervention:** BOPS launched in March 2011 combining a modified learning collaborative, real-time clinical data feedback to practitioners, quality improvement coaching, and a pay-for-quality monetary incentive using multidisciplinary onsite teams. **Design:** Comparison of 10 BOPS-participating sites (intervention) to 8 non-participating sites (control). **Setting:** A hospital-owned ambulatory network in the Bronx, NY. **Main Outcomes/Measures:** Rates of assessing sexual activity and ordering GC and HIV testing as documented in the adolescent template of the shared EMR; results of screening abstracted from the hospital's clinical information systems. **Results** Between March 2011 - May 2013, the quarterly rate (median of weighted averages) that clinicians documented sexual activity during visits (in the EMR adolescent template) increased from 37% to 84% at BOPS sites and from 7% to 62% at non-BOPS sites. Among youth with sexual history documented as sexually active, quarterly screening rates for GC increased from 67% to 86% at BOPS sites and from 38% to 78% at non-BOPS sites. Among sexually active youth, HIV screening increased from 54% to 74% at BOPS sites and from 33% to 70% at non-BOPS sites. Among all youth with a visit to a BOPS site (not limited to those with sexual history documented), the annual proportion of GC tests to individuals increased from 15.4% pre-intervention [2010] to 19.8% in 2011, and to 34.7% in 2012. The proportion steadily increased for males (2010-12.3%, 2011-16.4%,

2012-25%) and females (2010-17.9%, 2011-22%, 2012- 42.8%). At non-BOPS sites, the proportion of GC tests to individuals also improved from 12.1% pre-intervention to 14.7% in 2011 and 23.8% in 2012; the proportion increased less for males (2010-9.8%, 2011-11%, 2012- 16.4%) than for females (2010-14%, 2011-17.8%, 2012- 30.3%). Conclusions Our findings demonstrate an increase in rates of screening for male and female adolescents. Data from non-participating sites suggests that introduction of an adolescent template in the EMR results in improvement in screening rates regardless of participation in the BOPS collaborative; BOPS activities appear to promote additional improvement, especially for screening of adolescent males.

## Miscellaneous

### Presentation #46

#### **Development of an HIV Positive QI tool to track linkage to care at MMC**

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Background: No tool has existed to systematically track linkage to care of newly identified HIV positive patients despite the fact that Montefiore Medical Center (MMC) provides HIV testing and care to thousands of patients receiving inpatient, outpatient and emergency care. Aim: The quality improvement project aims to utilize laboratory data and IT programming to track newly-identified HIV positive patients and subsequent linkage to care throughout MMC. Methods: The tool uses laboratory evidence of CD4 and/or HIV Viral Load test results as a proxy for linkage to care. Measures: The tool highlights the difference between known HIV+ patients receiving repeat testing vs. newly identified HIV+ patients. In addition, the tool can identify HIV+ patients who have fallen out of care and were relinked to care through testing. Results: Results show the increase in overall HIV testing throughout MMC from 2011-2014 and the corresponding increase in newly identified HIV positive patients. Results further demonstrate the differences in linkage to care in five distinct outpatient settings with a minimum of 75% and maximum of 94% patients successfully linked to care within three months of diagnosis. The project presents lessons learned and recommendations for further investigation. Conclusion: Despite being a large medical system with multiple data systems, it is possible to monitor HIV linkage to care performance institution-wide.

### Presentation #47

#### **A 6 month Pilot of Phone/Text Reminder Messaging for Medication Adherence**

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The project aims is to test whether using automated text or telephone message reminders impacts medication adherence and retention and improve clinical outcomes in patients with HIV and suboptimal adherence. CICERO Program and BCHN decided to do a pilot project focused on using texting to remind patients with chronic detectable viral loads to take their medication. Preliminary results after six months for 24 patients showed 91% retention and that of the 19 patients who were retained, 4 additional patients had undetectable viral loads while none reverted.



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