



2015 NYC RING Convocation of Practices

Wednesday September 9, 2015




www.nycring.org



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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.nyccring.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
- Montefiore New Rochelle

2015 NYC RING Convocation of Practices

Wednesday September 9, 2015

Agenda

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

5:00 – 6:15 pm **Welcome**

Peter Selwyn, MD MPH

Chair, Department of Family and Social Medicine

Keynote Address

Kurt Stange, MD PhD

Distinguished Professor, Case Western Reserve University

Editor, Annals of Family Medicine

“Lenses to Understand Primary Care & Practice
Change”

Closing Remarks

M. Diane McKee, MD MS

Associate Professor and Director Division of Research,

Department of Family and Social Medicine

6:15 – 7:45 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

Multidisciplinary Team Care and Intensification Therapy for Diabetes

Marie-Louise Fabienne Daguilh, MD; Barnaby Sandra, RN CDE; Sherin Joseph, MPH, CHES; Terriann James, MS

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The prevalence of diabetes continues to grow in the USA, particularly in the Bronx where the rate (12.1%) is higher than the national average (8.3%). In 2006, the Williamsbridge Diabetic care team tackled this epidemic by developing a multidisciplinary approach to the care of patients with poorly controlled diabetes. This effort was supported by the American Association of Medical Colleges Chronic Care Collaborative. The team based their work on principles underlying the Chronic Care Model as well as the Patient-Centered Medical Home. Over the years, the team included physicians, residents, nurses, certified diabetic educators, health educators, social workers and psychologists. The team continues to report on the data collected and its experiences caring for high-risk diabetic patients since 2006.

Presentation #2

Diabetes in a South Bronx Clinic: Barriers to Care, Depression, and Perception of Glucose Control

David Herszenon, MD, MPH; Sandra Arevalo, MPH, RDN, CDN, CDE; Barbara Hackley, RN, CNM, PhD

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Context: Diabetes is a condition that affects more than 29 million Americans. Controlling diabetes can be challenging. This project seeks to understand factors that are associated with poor diabetic control. Methods: Patients at the South Bronx Health Center seeing their providers on days devoted to diabetes patients were surveyed with a questionnaire regarding their perceived barriers to glucose control, their perceived glucose control, and their depressive symptoms. A correlation matrix and backwards stepwise logistical regression were used to investigate how each of these variables related to patients' actual glucose control as measured by hemoglobin A1c. ANOVA was used to compare different levels of depression with glucose control. A t-test and a chi square were used to compare diabetic control in patients who felt their diabetes was well controlled to those who felt it was uncontrolled. Results: Forgetting to take medications was the only barrier predictive of poorly controlled diabetes as measured by a hemoglobin A1c of greater than or equal to 8.5. Those who stated remembering to take medication was a barrier were 3.169 times more likely to be uncontrolled than those who did not state it was a barrier. Younger age and taking insulin were also found to be predictors of poor control. Those who stated that they felt their diabetes was poorly controlled had a significantly higher average hemoglobin A1c (9.548) than those who felt their diabetes was controlled

(7.628), indicating some accuracy in patients' perceptions of control. Depression scores as measured by the PHQ-9 were not significantly correlated with glucose control. Conclusion: Patients who stated that they had trouble remembering to take their medications and those who felt their condition was poorly controlled were more likely to have poorly controlled diabetes. Therefore, these two questions may be most useful in determining patients most at need. Interventions helping patients remember to take their medications may be most helpful in controlling blood sugars.

Presentation #3

Dental Patients and Their Likelihood of Type 2 Diabetes Mellitus, Medical Visits and Dental Emergency

Julie Kazimiroff, DDS, MS

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Objective Design: We evaluated the burden of type 2 diabetes mellitus among adult dental patients receiving both medical and dental care at an urban healthcare system in the Bronx, New York City; estimated the incidence of emergency dental visits for those patients, and determined differences in the number of dental emergencies between patients with and without diagnoses of type 2 diabetes mellitus and those with good or poor glycemic control as measured by Hemoglobin A1C (HbA1C) values. *Study Design:* Data were generated from electronic dental and medical records for a period of six-months across seven Montefiore operated dental clinics. Medical records were queried using proprietary electronic health record data mining software (Clinical Looking Glass[®]) to determine HbA1C levels. In addition, we confirmed the type 2 diabetes mellitus diagnosis (DM) using International Classification of Diseases-9 Clinical Modification (ICD-9) codes 250.xx for diabetes. We identified dental emergency visits using Current Dental Treatment (CDT-2010) codes to identify types of dental visits. *Results:* During a six month period, there were 29,816 dental visits for unique patients. Of those 30 years old who had a medical visit within two years, we found that 8,486 (23.65%) had a diagnosis of type 2 diabetes mellitus. Patients with diabetes mellitus (DM) were more likely to be seen for dental emergency visits when compared to those without diabetes [OR of 1.2054 (95% CI: 1.0771-1.3491)] $p=0.0520$. We found that those with HbA1C ≥ 9 had increased dental emergency visits with an OR of 1.55 (95% CI: 1.1386-2.1042) $p < 0.01$. *Conclusions:* These data show there is an increased risk for a dental emergency for individuals with diabetes in a large urban health care system. In conclusion, patients with diabetes are more likely to experience pain and require emergency dental care.

Presentation #4

'I Felt Like it was God's Hands Putting the Needles In': A Qualitative Analysis of the Experience of Acupuncture for Chronic Pain in a Low-Income, Ethnically Diverse and Medically Underserved Patient Population

Benjamin Kligler, MD; Michele Buonara, BS; Jonathan Gabison, BA; Emilie Jacobs, MD; Alison Karasz, PhD; M. Diane McKee, MD MS

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Objectives: To examine the experience of patients from a low income, ethnically diverse medically underserved population receiving acupuncture for chronic pain. *Design:* Qualitative analysis using inductive thematic analysis of interviews with subjects from an acupuncture trial.

Settings/Location: Four community health centers in The Bronx, NY. *Subjects:* 37 adults with

chronic neck or back pain or osteoarthritis who participated in a previous acupuncture trial. Interventions : Up to 14 weekly acupuncture treatments. Outcome Measures: Pain and quality of life were examined in the original trial; this study examines qualitative outcomes. Results; The themes grouped naturally into three domains of the acupuncture experience: the decision-making process; the treatment experience; and the impact of acupuncture on health. Regarding decision-making, important factors were a willingness to try something new even if you do not necessarily 'believe' in it or have specifically positive expectations; a sense that medications were not working for their pain, that they also caused significant adverse effects, and that natural strategies might be preferable; and a feeling of desperation. Cost and access were significant barriers to acupuncture treatment. Regarding the process of acupuncture, the open and personal communication with the acupuncturist was an important factor, as was the sense that the process of acupuncture related to a natural process of healing or correction within the body and that part of making acupuncture successful required being open to the power of the mind to generate a positive outcome. Regarding their impact of treatment, notable aspects were the deep sense of rest and relaxation subjects reported during treatment as well as the benefits they experienced for conditions other than pain. Conclusions : The themes that emerged in our ethnically diverse, low income population were very similar to those that have emerged over the past decade of qualitative research on the acupuncture experience in other patient populations.

Presentation #5

Recruitment in Multi-Center Type II Diabetes RCT: Updated Challenges & Solutions

Jennifer Lukin, BS; Shira Hudes; Janet Brown-Friday, RN, MS, MPH; Jill Crandall, MD; M. Diane McKee, MD MS

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The GRADE (Glycemic Reduction Approaches in Diabetes: A Comparative Effectiveness Study) study is a NIH funded multi-center randomized clinical trial comparing the effectiveness of four commonly prescribed diabetes medications in combination with metformin. Randomized participants will take metformin and either Glimepiride (Amaryl), Liraglutide (Victoza), Sitagliptin (Januvia) or Glargine (Lantus). There will be 5,000 participants across the U.S and 150 patients from each center. The Einstein GRADE study team began recruitment in June 2013. The primary recruitment method is identification of participants via Montefiore Medical Center's Electronic Medical Record (EMR). This presentation discusses the challenges encountered during recruitment and how they have been managed over the course of the study, and in particular during the past year.

Presentation #6

Acupuncture Approaches to Decrease Disparities in Outcomes of Pain Treatment (AADDOPT-2)

M. Diane McKee, MD, MS; Benjamin Kligler, MD, MPH; Arya Nielsen, PhD, LAc; Belinda Anderson, PhD, LAc; Jennifer Halstead-Kenny, MD; Eric N. Gil, BA; Tanairi H. Quezada, BS

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Chronic pain is a major public health concern that places numerous burdens on individuals, including both physical and psychological impairment, decreased productivity, and side effects due to medication use. Extensive evidence now supports the use of acupuncture therapy to treat chronic pain

conditions. Minority populations differ both in prevalence and outcomes of chronic pain, in part related to disparities in access to care. Acupuncture therapy is slowly being integrated into pain management in many conventional healthcare settings, but cost and reimbursement obstacles remain, especially in primary care and safety net settings. Group acupuncture care is now offered in many settings because it can be provided at lower cost. Demonstrating similar effectiveness between individual and group acupuncture could reduce barriers to expanding access to this effective pain management approach. The Acupuncture Approaches for Chronic Pain trial is a stakeholder-engaged randomized comparative effectiveness study to assess outcomes of individual and group acupuncture therapy for treatment of chronic pain. Approximately 700 patients will be recruited from 6 participating health centers and randomly assigned to receive acupuncture in either an individual or group setting for 12 weeks. We will compare outcomes, meaningful to patients, including pain and quality of life. To better incorporate patient perspectives into intervention delivery and dissemination, a subgroup of 20 participants from each arm (individual/group) will be interviewed. This will provide guidance on how to integrate patient experiences into implementation. A robust stakeholder group with representatives from our patient population, acupuncture and primary care clinician communities, payor organizations, and pain management advocacy groups meets quarterly to discuss and provide input on implementation, interpretation of results, and dissemination. Acupuncture therapy sessions began 5/18/2015, 316 patients have been referred by their primary care providers and 66 patients have initiated treatment. Additional acupuncture sessions have been added to increase capacity to accommodate referrals.

Presentation #7

Learning from Stakeholders: Early Lessons from the Acupuncture Approaches for Chronic Pain Project

M. Diane McKee, MD, MS; Benjamin Kliger, MD, MPH; Arya Nielsen, PhD, LAc; Belinda Anderson, PhD, LAc; Jennifer Halstead-Kenny, MD; Eric N. Gil, BA; Tanairi H. Quezada BS
Contact: diane.mckee@einstein.yu.edu

Chronic pain is a major public health concern that places numerous burdens on individuals, including both physical and psychological impairment, decreased productivity, and side effects due to medication use. Group acupuncture care is now offered in many settings, because it can be provided at lower cost. Demonstrating similar effectiveness between individual and group acupuncture could reduce barriers to expanding access to this effective pain management approach. The Acupuncture Approaches for Chronic Pain trial is a stakeholder-engaged, randomized comparative effectiveness study to assess outcomes of individual and group acupuncture therapy for treatment of chronic pain. Stakeholder engagement is defined as meaningful involvement of patients, clinicians, and other stakeholders throughout the research process. The stakeholder engagement plan for this study includes 3 Patient Partners, who are key personnel for the project, participate in team meetings, and provide input on many aspects of the study. A robust Stakeholder Advisory Group with representatives from our patient population, acupuncture and primary care clinician communities, payor organizations, and pain management advocacy groups met in an initial retreat and quarterly to discuss and provide input on implementation, interpretation of results, and dissemination. To date our stakeholders have already made major contributions. The Stakeholder Advisory Group met in an initial retreat in February and provided input on measures, delivery of group acupuncture, and incorporation of patient perspective. Our Patient Partners are receiving acupuncture as participant observers, join our team meetings, provide feedback on consent and other materials for patients,

among other contributions. The acupuncturists are completing a weekly survey to capture incidents, challenges and successes, which are then discussed with the full team. Challenges to implementing the engagement plan include adapting the 'academic consultant' mechanism to pay the Patient Partners, and requirement that they complete human subjects training.

Presentation #8

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

Serena Roth, MD; Joanna Starrels, MD, MS; Charleen Jacobs, ANP; Sarah Ricketts, MD; Darlene DeSantis, PhD; Naum Shaparin, MD; Laila Khalid MD, MPH

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Mental health and substance use problems are common among patients with chronic pain. Primary care providers (PCPs) lack the necessary training and support to optimally manage chronic pain, mental health, and substance use disorders. The Collaborative Pain Intervention for Long-term Opioid Treatment Safety (CoPILOTS) program was a collaborative care model to integrate pain care management and behavioral health into primary care. The objectives of the CoPILOTS program were to 1) develop and pilot a collaborative care model for chronic pain management in primary care, and 2) determine whether the program was associated with improved screening for mental health and substance use problems, safer opioid prescribing practices, and patient pain, functional, and substance use outcomes. Patients were referred by their PCPs at the Montefiore Family Care Center (FCC) Internal Medicine Practice. Eligible patients were adults with a chronic pain condition, with suboptimally controlled pain or psychosocial challenges. Initial criteria required patients be on chronic opioid therapy; this was modified mid-year. The CoPILOTS multidisciplinary team included a pain care manager (nurse practitioner), behavioral health manager (psychologist), two primary care champions, a psychiatrist and a pain specialist. The program included monthly pain and opioid assessments with recommendations to the PCP, a patient self-management program, mental health and substance use screening, treatment with the behavioral health manager if indicated, and facilitated referrals for specialty services. From August 2014 to June 2015, 103 patients were referred to the CoPILOTS program; 56 completed evaluations. Among those who completed initial evaluations, 40 met criteria for referral to the behavioral health manager. CoPILOTS patients had a high burden of trauma and concurrent mental illness. Patients reported very high rates of disability, pain catastrophizing, depression, and anxiety. Enrollment challenges included physician referrals, provider continuity, patient refusal, and transportation. Many patients considered themselves too physically or psychologically disabled to participate fully in the self-management program.

Community Health

Presentation #9

COPC-PH: Community Oriented Primary Care from the Public Health Perspective

Earle Chambers, PhD, MPH; Barbara Wong, MPH; Rachel Riely, MPH; Nicole Hollingsworth, PhD; Arthur E. Blank, PhD; Christina Myers, MPH; Jane Bedell MD; Peter Selwyn, MD

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Research Objectives: 1) Compare clinically derived lifestyle behavior data with population-level data from the same geographic area. 2) Analyze data regarding physical activity and nutrition collected through the electronic medical record (EMR) for primary care patients at three Bronx neighborhood health centers. 3) Compare results with neighborhood-level data for these same public health variables. Study Design/Methods: Through a collaborative effort by Bronx-based Montefiore Medical Center, the New York City Department of Health and Mental Hygiene, and the Bronx Ambulatory Care Network, data elements were identified for collection and analysis. Five Behavioral Risk Factor Surveillance Survey (BRFSS) questions, from the NYC Community Health Survey, assessing physical activity and nutrition were integrated into the Medical Center's EMR. The questions were programmed to pop-up automatically once-yearly on the EMR intake vital sign assessment screen. Patients 18 years of age, attending one of three health centers between February and December 2012 were included in analysis. Principal Findings and Quantitative/Qualitative Results: Between 35% and 43% of patients reported no physical activity in the past 30 days. In the neighborhoods surrounding the health centers, residents reporting no physical activity in the last 30 days ranged from 18%-29%. Approximately half of patients reported walking or biking for transportation in the last 30 days, while the proportion was closer to 80% among neighborhood residents. Most patients and neighborhood residents reported consuming 1-4 fruits and/or vegetables daily. Patients at one health center reported a lower consumption of 1 sugary drinks/day than the surrounding neighborhood. Conclusions/Impact on Health Centers: A higher proportion of health center patients than neighborhood residents reported unhealthy lifestyle behaviors. Health centers are neighborhood hubs for public health. However, health centers and public health agencies rarely operate in concert to increase population wellness. The systems for collecting and analyzing patient- and population-level data are often not coordinated or connected, making the examination of patient outcomes difficult to interpret within the context of population trends. By embedding validated lifestyle questions collected at the population-level into routine EMR workflows, the effect of clinical care on population health can be measured and interventions developed to target patients and neighborhood populations.

Presentation #10

The Problem with Urban Food Pantries: Unreliable, Hard-to-Access, Not-so-Healthy Food for Some of our Most Vulnerable Patients

Sean Lucan, MD, MPH, MS; Zoë Ginsburg, Medical student; Hilary Frankel, Medical Student

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Context: Family physicians care for vulnerable--sometimes food-insecure--patients, often afflicted with diet-related diseases. Even excellent physician management might not overcome patients' poor access to healthy food. Most research on food access has focused on select stores and restaurants with little attention to sources of emergency food like pantries. Objective: To assess the accessibility of food pantries and the availability and quality of the foods they offer in two urban areas. Design: Cross-sectional. Setting: Bronx, NY. PARTICIPANTS: randomly selected food pantries: 40 of 73 in Area A (high-poverty, predominantly Black-and-Hispanic communities; poor health outcomes), 12 of 15 in Area B (more-mixed lower-income communities; somewhat better health outcomes). Outcome Measures: Accessibility of pantries (days and hours of operation, eligibility criteria for use), availability of foods (by government MyPlate and other nutritional categories), and food quality (by appearance and package dates). RESULTS: For accessibility, 51.9% of randomly selected pantries

were completely out of food or closed when supposed to be open. Pantries operated few hours (3.3 hours over 1.6 sessions/week on average); only 17.1% had any hours outside the 9am-5pm workday. Pantries in Area A were open a mean of 20 fewer minutes per session than pantries in Area B (difference not statistically significant). 80.0% of assessed pantries in Area A had some eligibility criteria (e.g., requiring documentation of age, residential zip code, and/or employment) compared to 20.0% of assessed pantries in Area B ($p=0.002$). Analysis of food offerings suggested limited availability (median 12 items per pantry), low nutritional value (e.g., 23.8% of items refined grains, sweets, or sugary drinks) and poor quality (e.g., 12.8% of packaged items past expiration), all worse in Area A (p values NS). Conclusions: Urban food pantries may be unreliable sources of difficult-to-access, not-so-healthy, poor-quality food, particularly in the most needy communities; family physicians should be aware.

Presentation #11

The Effect of Centering Pregnancy Implementation on Key Indicators of Maternal/Neonatal Health

Carole Ann Moleti, DNP, MPH, CNM, FNP-BC; Peter Bernstein, MD, MPH; Dana Schonberg, MD, MPH; Rebecca Mahn, BS

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Preterm birth (PTB) and low birthweight (LBW) babies are the source of a large burden of infant, neonatal, and childhood morbidity. The purpose of this project was to expand the use of the CenteringPregnancy Group Prenatal Care Model as an evidence-based intervention for management of both medical and psychosocial risks in low-income, ethnic minorities, and racial minorities in New York City. The standardized, validated model developed by Schindler Rising decreases the incidence of preterm birth and low birthweight and increases the rate of breastfeeding. A CenteringPregnancy program implementation plan, customized to meet the needs of a multisite urban hospital system, was coordinated with the Centering Healthcare Institute to ensure method fidelity while allowing for an individual site's particular needs based upon patient demographics and provider mix. Program evaluation showed that the logic models supported implementation and expansion of Centering Groups at 2 Federally Qualified Health Centers, with adequate progress toward site approval and method fidelity scores, and favorable patient and staff satisfaction ratings using the CenteringCounts data collection system. The preterm birth rate for the 44 women who completed the six group cycles, two from each site, was 9%. The current institutional rate ranges from 12.8 to 14.7% with an average of 13.8%. One woman out of 26 delivered a LBW (not preterm) baby who did not go to NICU. The institutional rate of LBW in infants born after thirty-seven completed weeks has not yet been determined, but the Bronx baseline is 10% (Bronx Health Link, 2013). Ninety-three percent of Centering participants were breastfeeding at hospital discharge. The institutional average is 88% (New York State Department of Health and Mental Hygiene, 2015). The cesarean section rate amongst Centering participants was 20.5%. The institutional average is 33% (NYSDOHMH, 2015) and the Healthy People 2020 target is 23.9% (United States Department of Health and Human Services, 2011). Prenatal care was adequate for all Centering participants. Retrospective case review demonstrated that medical and/or obstetrical high-risk status was not a predictor of PTB or LBW in this sample, with the majority (7 out of 8 high medical/obstetrical risk women) delivering average for gestational age (AGA) babies at term with no NICU admissions. In order to foster a change in policy toward Centering as the default option for prenatal care, an ongoing study is underway to assess the

reduction of and fiscal impact on preterm and low birthweight rates to offset the cost of implementation.

Presentation #12

Building Healthy Local Communities

Doug Reich, MD; Jose Tiburcio, MD; Rao Kadiyala, MBBS; Patrick Maseo, MS

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Claremont Village is located just south of the Cross Bronx Expressway in the Morrisania-High bridge sector of the South Bronx. Home to more than 11,000 people across 5 complexes, which include more than 30 buildings, Claremont Village is one of the larger public housing developments in New York City. The complexes spread across an area roughly 10 city blocks, just east of Bronx-Lebanon Hospital Center. The residents of Claremont Village and the surrounding communities have very limited financial resources. The congressional district where Claremont is located is among the poorest in the country. The average yearly income for residents in the zip code where Claremont Village is located (10456) is \$16,664, while average yearly incomes on many individual blocks are under \$14,000. Poverty has been shown to be the single strongest driver of poor health outcomes. Over three years ago the Department of Family Medicine at Bronx-Lebanon Hospital Center, the American Diabetes Association (ADA) and Health First, founded the 'Claremont Healthy Village Initiative' (CHVI) with the aim of addressing this large disparity. The initiative started with a vision of improving the health outcomes and empowering residents within the Claremont Village New York City Housing Authority (NYCHA) developments. The targeted NYCHA developments are home to more than 11,000 residents, located in the South Bronx's Morrisania neighborhood. While CHVI is committed to providing our members with the highest quality healthcare, we know that health is driven by much more than a patient's medical situation. Health outcomes are also impacted by a community's healthcare culture--the way a community thinks about their health and how they experience healthcare. While we may not be able to eradicate poverty, CHIV aims to play a prominent role in offering our communities the tools they need to improve their health and have positive interactions with the healthcare system. Our goal is to offer an integrated, coordinated model of care and to empower the residents to take control of their health.

Presentation #13

Nurse Family Partnership

Angela Schonberg, MPT; Paul Meissner, MSPH; Pamela Joachim, MS, RN

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Montefiore will be implementing Nurse Family Partnership. This is an evidence based, community health program to improve prenatal care, quality of parenting and life prospects for mothers by partnering them with a registered nurse. The program will benefit first time mothers, who are poverty level, and follow the mom and child from no later than 27 weeks gestation, until the child turns two years old.

Presentation #14

Montefiore Medical Centers Housing at Risk Program

Deirdre Sekulic, MSW; Bernice Asamoah, MPH

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Overview: The Housing at Risk program tested a variety of interventions in offering housing support to the vulnerable population in the Bronx. The program provides coordinated health and housing support from the hospital to the community while improving multi-professional teamwork both within and outside the institution. Through this work, Montefiore is better able to position itself as an ACO (Accountable Care Organization and Health Home). Interventions: Housing at Risk works at identifying people who are unstably housed (street homeless, shelter homeless, staying with others, losing their housing, inappropriately housed, etc.) at the point of ED registration, alerting the ED Social Workers, patient navigators and others with information about the patient in real time and improving coordination at points of patient hand off both when admitted and at discharged. The program also improves multi-disciplinary teamwork in the ED for patients by incorporating all members of the team in treatment with a focus on housing and behavioral needs and housing-based community referrals. Results: An appropriate decrease in admission rates, improved relations with community partners, permanent placement in housing for high service utilizers, and an expansion of interdisciplinary awareness and ideas around housing and healthcare were all outcomes of program implementation. By contrast, the stigma of homelessness, lack of outpatient services and housing options, lack of awareness around the role of housing among interdisciplinary team members and difficulty engaging disenfranchised patients were all documented barriers. Conclusion: Better patient outcomes, improved community collaboration and provider awareness are potential benefits of adding a housing alerts and interventions system in Emergency Room settings.

Presentation #15

Project INSPIRE: Transforming Hepatitis C Care at Montefiore

Shuchin Shukla, MD, MPH; Magdalena Slosar, MD; Alain Litwin, MD, MPH, MS; Kim Yu, MPH

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Hepatitis C is an overlooked disease. It is estimated that half of the 150,000 New York City residents with hepatitis C do not know they are infected. Only a fraction are engaged in care, let alone cured. With the recent FDA approval of many new medications, however, there is a renewed push to engage these patients and cure them, thereby decreasing their risk of cirrhosis, cancer, and early death. Montefiore's Project INSPIRE aims to improve the 'Cascade of Care', from increasing identification of undiagnosed cases, to expanding access to care in the patient's medical home, to providing care coordination and addressing barriers to care. INSPIRE's 10 outpatient sites connect patients to the newest innovations in hepatitis C care: elastography to assess for cirrhosis and all-oral medications with 95% cure rates. Multidisciplinary weekly tele-mentoring conferences are geared to train primary care providers to treat hepatitis C themselves and still have support from hepatologists and mental health experts for complex cases. Data is used to find patients lost to follow-up, track their progress through medical work-up and treatment, and compare outcomes. With a goal to enroll 2100 patients from Sept 2014 - Aug 2017, INSPIRE will create a new model for outpatient non-specialist based hepatitis C care that can eventually be applied in diverse clinical settings.

Presentation #16

Collaborative Care to Reduce Depression and Increase Cancer Screening among Low-Income Urban Women - Recruitment Update at Urban Health Plan

Franco Barsanti, PharmD; Alejandra Morales, PsychD; Sasha Garcia; Jennifer Concepcion; Tracie Urban, BSN, RN; Tzyy J. Lin, MPH; Andrea Cassells MPH

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The Bronx in New York City is among the nation's poorest urban counties in the U.S. The Bronx is predominantly Latino and African-American. Cancer is the leading cause of premature death in the Bronx. Low-income minority populations are more likely to be diagnosed with preventable and late-stage cancers than the general population, in part due to lower screening rates. Much research has addressed screening barriers in low-income minority groups, but depression, a potentially critical barrier, has received scant attention. Research suggests that depressed women are less likely to engage in cancer screening, especially mammography and Pap testing. The link between mental health and cancer screening is particularly important to address in the Bronx, which has the highest rates of self-reported serious psychological distress in New York City. Depression affects almost 1 in 4 minority women, and while minorities often seek help for depression in primary care, primary care depression management often does not meet evidence-based standards. This study will 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. To achieve this, we will compare the effectiveness of these two interventions using a randomized controlled trial. This study will recruit from 3 Bronx Health Centers and 3 NYC Health and Hospital sites, approximately 700 women ages 50-64 who screen positive for depression and are nonadherent with necessary cervical, breast, and/or colorectal cancer screenings. Urban Health Plan is a network of federally qualified community health centers located in the South Bronx, which provides primary and specialty care to approximately 70,000 patients. UHP has screened 461 patients, enrolled 162 patients, and completed 106 initial intervention calls.

Presentation #17

Planning a Continuous Quality Improvement Initiative for Routine HIV Testing at Montefiore Outpatient Sites

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Background: For over a decade, the Adolescent AIDS Program has provided technical assistance to the Montefiore Medical Group (MMG) outpatient sites to achieve routine HIV testing. In 2010, New York State law mandated routine offer of HIV testing which prompted Montefiore to establish an institution-wide Routine HIV Testing Task Force. Data from 2014 reveal a wide variation in HIV testing performance across the 23 MMG sites. Overall, only 28% of eligible patients (13-64, primary care visit, non-pregnant) were tested for HIV in 2014, a rate that has been relatively steady since 2011. 59% of patients had any evidence of HIV testing at Montefiore. Significant legal and operational changes (elimination of requirement for written consent; transition to new EPIC EMR

system) necessitate a dedicated CQI initiative to improve HIV Testing. *Aim: All MMG sites will be expected to provide HIV testing to at least 70% of eligible patients by the end of 2016. Ten high volume outpatient sites and three urgent care facilities have been chosen to receive the first phase of technical assistance. Methods: To achieve this CQI target, the initiative will secure buy -in from MMG leadership at each site; plan for implementation with strategies tailored for each facility; train staff on the new EPIC workflow for testing; and provide ongoing monitoring and evaluation. Measures: Tracking data will measure the number of unique, eligible patients who receive an HIV test, compared to the total number of eligible patient visits. Data is currently collected using Clinical Looking Glass and will be updated to include testing data in the EPIC system. Outcome: Ongoing technical assistance will help achieve compliance with the NYS mandate for routine offer of HIV testing and ensure that 70% of patients are tested for HIV by the end of 2016.*

Presentation #18

Medicaid Coverage for Breastfeeding Support Following ACA and Medicaid Provisions

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Background: International Board Certified Lactation Consultants (IBCLCs) are associated with increased rates and duration of breastfeeding. Recent legislation offers opportunities for private and public insurers to include IBCLC services as a covered benefit. Objective: To explore states' Medicaid coverage of IBCLC services following January 2014 legislative expansions of coverage for preventive health services. Methods: To assess IBCLC reimbursement practices, 20 states, stratified by Medicaid expansion (Yes/No) and 3-month exclusive breastfeeding rates, were selected to participate. An electronic survey was sent to Medicaid and Maternal Health Directors, breastfeeding coordinators and WIC coordinators between July-December 2014. Email follow-ups clarified missing or ambiguous responses. Results: Of the 15 states responding, 9 had Medicaid expansion. None of the states permitted IBCLCs to bill for services autonomously. In 9 states, IBCLC services were covered with some type of stipulation, e.g., billing under a physician. Of the 9 states with IBCLC coverage, 7 had accepted Medicaid expansion. States with higher rates of exclusive breastfeeding were also more likely to provide IBCLC coverage. Conclusion: Recent legislative changes to public and private insurance that could expand coverage of IBCLCs have not yielded appreciable changes, particularly in states without Medicaid expansion. There is a need for research on the effects of adopting expanded coverage for IBCLCs, and advocacy to do so.

Presentation #19

Well Baby Group Care: Evaluation of a Promising Strategy for Primary Prevention of Childhood Obesity

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Objective: To evaluate the effect of Well Baby Group (WBG) versus traditional one-on-one care on rates of overweight/obesity at age 2 years. Design: Quasi-experimental, observational comparison group study. Setting: The South Bronx Health Center, a federally qualified community health center

that serves residents of one of the poorest congressional districts in the country. *Sample:* Children with a 2-year well child care visit in 2009-2013 who were seen within the first 2 months of life and had ~3 well child care visits before their second birthday. The intervention group included all eligible children who received care in WBG (n=47); the comparison group was randomly selected from eligible children born over the same time period who received traditional care (n=140). *Intervention:* WBG is an alternative to traditional one-on-one care, consisting of 11 well child care visits over the first 18 months of life, conducted in a group setting and facilitated by a pediatrician and nutritionist. Each 2-hour session includes health assessment, group discussion and interactive learning using a nutrition-focused curriculum. WBG fosters positive dietary behaviors for mother and infant, responsive feeding practices, and peer support. *Results:* No differences were seen in demographic and baseline characteristics of mothers and children who participated in group compared to traditional care. Children in WBG were significantly less likely to be overweight/obese (BMI-for-age ~85 percentile) at age 2 years compared with children receiving traditional care (2.1% vs. 15.0%; OR, .123; 95% CI .016-.942; P=.02). Logistic regression analysis was used to control for known predictors of toddler weight (i.e. birth weight) and demographic differences between groups (i.e. parity). After controlling for potential confounding variables, WBG remained a significant independent protective factor for overweight/obesity at age 2 (OR, .120; 95% CI, .015-.931; P=.04). *Conclusions and Relevance:* WBG appears to be a promising strategy for primary prevention of pediatric obesity. Further research is needed to confirm these results.

Presentation #20

Engaging Latina Breast Cancer Survivors in Follow-up Care

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Race and ethnicity have been found to be one of the strongest predictors of non-adherence to post-treatment breast cancer surveillance, with survivors of color demonstrating a lower likelihood of completing an annual mammography, compared to white survivors. Among breast cancer survivors, Latina survivors are a medically underserved group that may benefit greatly from a tailored health communication intervention. Method: Using a two-arm randomized design, we will test the effect Latina breast survivor narratives presented in a health communication DVD intervention (DVD versus usual care). *Participants:* We will engage a sample of (N=350) Latina breast cancer patients via various recruitment strategies, including MMC clinical records/tumor registry, electronic media, and Bronx based clinic outreach. All study activities will be offered in both Spanish and English. Eligible participants are 1) 3 to 48 months post-primary breast cancer treatment, 2) female, 3) self-identify as Latina/Hispanic, 4) 21-74 years of age, 5) diagnosed with either in situ or Stage I, II, or III disease and 6) live in the Bronx and NYC. This study begins recruitment in September 2016. *Hypothesis:* We expect that participants who are less acculturated, report more difficulty with medical interactions, and have greater medical mistrust will be more likely to adhere to guideline surveillance when assigned to the DVD arm versus the usual care arm. We also expect that in the DVD arm versus the usual care arm, effect on adherence will be mediated by positive attitudes towards post-treatment surveillance modalities, perception of strong social norms supporting surveillance, high perceived self-efficacy and behavioral control over participating in surveillance, strong intention to participate in surveillance, and fewer environmental constraints on one's surveillance behavior. *Conclusions:* Our final DVD will contribute to research on effective cancer health communications for the

Latina/Hispanic communities of NYC. Results will inform effective ways to mitigate barriers to post-treatment care.

Presentation #21

Pilot Testing a Peer Support Weight Loss Group at an FQHC in the Bronx

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Background: Obesity is highly prevalent in underserved communities in the Bronx, New York. Healthy food options are limited and outdoor green space is sparse. In addition, patients in these communities cannot afford commercially available weight loss alternatives. Objective: To establish and make accessible a peer support weight loss group that is tailored to the needs of patients in socioeconomically underserved areas. Design/Setting: Weekly 1-hour peer support group sessions were conducted at the Family Health Center (FHC) of Montefiore Medical Center in the Bronx, NY from February-November 2013. The sessions were free of charge and made available to any patient receiving care at FHC. Participants were encouraged to attend as many sessions as possible. Data collected included attendance and weight. Results: Thirty-three group sessions were conducted during this period. A total of 37 participants attended at least one session. Of these, 20 participants attended ~ 2 sessions and were included in the final analysis. The mean weight loss was 4.3 lbs. Eighty percent (16/20) of participants maintained or lost weight. Six participants lost ~10 lbs (5% body weight change). Also, 5 /7 (71%) participants who attended > 10 sessions lost %à'10 lbs. Conclusions: Peer support groups are an effective weight loss option for patients in socioeconomically underserved areas. Our data suggests that most patients can maintain or achieve a clinical significant weight loss (5% body weight change), the latter seems to correlate with participation in > 10 sessions.

Presentation #22

Sleep Survey in Primary Care

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Objectives: To describe sleep problems and co-morbid conditions in Bronx primary care patients, and perceived utility of sleep screening by their providers. Setting: Williamsbridge and Family Health centers. Participants: English or Spanish-speaking adults, recruited from the waiting areas. Procedures: Participants completed the Insomnia Severity Index (ISI) and the Berlin Sleep Apnea Questionnaire (Berlin) screeners, and self-reported physician diagnosis of medical conditions. Height and weight were obtained from medical records. Graduate students gave the screening results to primary care providers, prior to their seeing the patient. Results: Participants (n=97), who were predominantly women (77%) and had a mean age of 44.5 (SD = 16.7), reported sleeping 6.2 hours/night (SD = 1.7) with 31 minutes to sleep onset (SD = 37.0). On the ISI, 30 participants (31%) screened positive for clinical insomnia [severe=7% moderate=24%]. On the Berlin, 32 participants (33.0%) screened 'high risk' for sleep apnea; this rate will likely increase as currently missing BMI data for n=73 is added to calculation of the Berlin. Nearly 40% of participants wanted to get help with their sleep now; 12% were currently getting help for sleep problems. Nearly 30% had previously

sought help. Comorbidities included high blood pressure (45%), cardiovascular disease (12%) and diabetes (24%). An additional 14% reported chronic pain, and 12 % reported migraine diagnoses. Chronic pain diagnoses were more common among persons with vs. without clinically significant insomnia (57% v. 27%, $p<0.05$). No other diagnoses were associated with screener findings. For the 24 participants with BMI data, 63% were classified as obese. Providers ($n=37$) reported that the screening tools were at least somewhat useful (73%) and brought sleep to their attention (51%). Fewer reported that they informed patient counseling (16%), testing (5%), and referrals (5%). Conclusions: There appears to be a high unmet need for screening and treatment of sleep problems in primary care.

Presentation #23

The Healthy Smiles Project: Oral Health Core Clinical Competency Pilot Project

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Purpose: The goal of this project is to adopt and implement oral health core clinical competencies using a sustainable systems-approach that results in integrating oral health and primary care through inter-professional collaborative practice. Objectives include: 1) Increase oral health screening and preventive services 2) Increase oral health integration in primary care practice. 3) Increase care coordination between medicine and dentistry. Methods: The project was implemented at a large federally qualified health center complex, which has co-located medical and dental services. The population of focus was 9 months-47 months. Pediatricians were trained in caries-specific patient screening and assessment. Education was accomplished by two methods: 1) didactic seminars given by the Department of Dentistry on core oral health competencies and 2) requirement to complete an online oral health curriculum (Smiles for Life). Recognizing that the integration of oral health content into practice is most successful when introduced during training, Smiles for Life was added as a requirement to pediatric residency education. A new oral health risk assessment tool was added to the pediatric electronic medical record. Fluoride varnish was initiated as a preventive service to all high-risk patients and is applied in pediatrics. Posters and pamphlets were generated to reinforce the importance of this project and establishment of a dental home by age 12 months. To address care coordination and improve patients' access to dental appointments, a new reservation code was established during this project, allowing patients to schedule a dental appointment within pediatrics. Medical and dental teams tracked monthly data to evaluate progress and sustainability, with the goal of increasing dual care to children during the grant period. Results: Data for the following: 1) Count of Oral Health Assessments Performed 2) Count of Fluoride Varnishes Performed and 3) Percentage of all Dental Visits made by Cohort Members were graphed on a monthly basis for the project's duration. The results showed an increase in the above parameters during the project, with increased oral health services used. Conclusions: This pilot project demonstrates that primary care providers can be successfully trained in oral health core clinical competencies. Increased focus in primary care and inter-professional collaboration leads to increased identification of children at high risk for caries, ability to provide evidence-based caries preventive services such as fluoride varnish at an earlier age, and establishment of a dental home at the appropriate time.

Presentation #24

Global Health Delivery Science: Applying the Care Delivery Value Chain Framework to a Community Based HIV/AIDS Initiative in Togo, West Africa

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Background: The global health delivery gap refers to an inability to provide existing medical discoveries to the individuals who need them. Resolving such inequity may represent medicine's most important duty. The new field of 'global health delivery science' aims to address such gaps. An approach in this new field utilizes the care delivery value chain (CDVC) framework to facilitate inefficiencies and gaps in provision of care across a continuum. There is limited published data describing the application of the CDVC framework to programs aimed at resource poor or pediatric populations. Design/methods: A CDVC assessment was planned for a community-based clinic serving 1,700 individuals living with HIV/AIDS, including 154 children. Multiple semi-structured interviews were conducted with 11 local staff members to gather detailed information about existing HIV/AIDS services, including pediatric care. The researcher compiled the results of these interviews into a draft CDVC framework and quality improvement (QI) plan. Results: The CDVC framework identified activities currently available for discrete stages within a cycle of care including: Prevention & Screening, Diagnosing & Staging, Pre-antiretroviral Management, Antiretroviral Initiation, Continuous Disease Management, and Management of Complications. Within these care continuum areas, twenty-eight specific gaps in service delivery were identified, including three distinct pediatric issues, and were integrated into a strategic QI plan. Within three months, seven identified gaps were resolved, and six months into the initiative 25 out of 28 delivery gaps were being addressed. Significant gaps in transitions between care stages were elucidated including gaps in pediatric care delivery, areas that would likely not have been identified through traditional assessment methods. Multiple areas of overlapping services by external providers highlighted inefficiencies in the overall delivery system and can inform future programmatic decisions.

Presentation #25

Reducing Hospital Readmission Rates in a High Risk Medicaid Population through Collaborative Coordination

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Background: Montefiore participated in a 3 year NYS lead Hospital-Medical Home Demonstration (HMH) project which aimed to improve health care provided to Medicaid members in sites that train residents to become primary care physicians and improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings used by teaching hospitals to train resident physicians. Among the grant requirements were PCMH recognition, resident continuity improvements, integration of physical/behavioral health, sepsis recognition and management of clinical performance metrics and care transitions metrics. Aim: Reduce hospital readmission rates among a high risk Medicaid population within 8 Montefiore

primary care sites. *Methods:* Patients were stratified by risk for readmission and those at higher risk were called by 2 dedicated registered nurses from the CMO Care Transitions team who performed comprehensive post discharge assessments of patients to determine gaps in patient knowledge, care and services needed and ensured that those services were in place. A hand off was made to Chronic Care nurse at the patients' PCP's office. Assessment results were communicated to the PCP via the electronic medical record. Chronic Care nurses would follow-up with patients at post discharge office visits. Chronic Care nurses performed outreach to those patients who did not show. *Results:* Follow-up phone calls within 48 hours of discharge increased from a baseline of 11% to 80% over a 2 year period. There was a reduction in 30 day readmission from 32% to about 19% for our High Risk Medicaid patients.

Presentation #26

Patient Perception and Satisfaction on Physician Attire

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Due to growing uncertainty and perception regarding the physician dress code, we created a survey to examine the influence of physician attire on patient perception including trust, satisfaction and confidence. Setting, Participants, intervention: We conducted an anonymous survey in our family medicine clinics asking the patients in the waiting room, Studies that: (1) involved participants ~18 years of age; (2) evaluated physician attire; and (3) reported patient perceptions related to attire were included. This study was conducted for a period of 1 week Results: Overall, 69.9% of the 153 patients surveyed preferred doctors to wear white coats. Patients disliked bare-below-the-elbow attire, scoring it lowest on the comfort and confidence scales (0.05 and 0.09, respectively). Information regarding risks of coat-carried infections did not influence respondents' opinions; 86.9% would still feel comfortable with a doctor who wore one Conclusions: Attire is one of the important factors that inspire patient confidence in physicians. White coats and professional formal were deemed the most appropriate clothing style for doctors, followed by scrubs. However, older participants perceived scrubs to be less appropriate attire than younger subjects.

Presentation #27

Risk Factors for Postpartum Emergency Department Visits among a High-Risk Obstetric Population

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Objective: To identify clinical and psychosocial risk factors associated with postpartum emergency department (ED) utilization. Study Design: We identified one hundred consecutive postpartum women who delivered between 2012-2013 in a large integrated medical system who subsequently had an ED visit within 42 days of delivery. These were matched with controls by labor unit, delivery mode and date in a 1:1 ratio. Nonviable pregnancies were excluded. Variables included demographics, antenatal/intrapartum/postpartum complications and neonatal intensive care (NICU) admission information. Univariate and multivariate analyses were used to identify factors associated with puerperal ED use. Results: Univariate analysis suggested women who were nulliparous (multiparity OR 0.48, 95% CI 0.28-0.81), were publically insured (OR 1.02, 95% CI 1.02-3.44), developed hypertensive disease (OR 2.60, 95% CI 1.26-5.39), or had a complicated delivery event (OR 2.27, 95%

CI 1.24-4.16) were more likely to seek ED care postpartum. Following conditional logistic regression, multiparity (OR 0.07, 95% CI 0.10-0.41), public insurance (OR 3.96, 95% CI 1.52-10.33) and delivery-related complications (OR 3.00, 95% CI 1.15-7.87) remained significantly associated with postpartum ED use, as did an interaction term showing a significant effect modification among women who were 34 years old or greater and unmarried (OR 1.22, 95% CI 34.89-536.69). GBS colonization, obesity, gestational age at delivery, medical or psychiatric history, antepartum complications, postpartum anemia, and NICU admission were not significantly associated with a postpartum ED visit. Conclusion: Postpartum ED use is costly to the health system and disruptive to the lives of women and their families. Recognizing factors identifying postpartum women at higher risk for seeking ED care would allow for targeted interventions to improve care during the puerperium and potentially prevent ED visits.

Mental Health

Presentation #28

Development of a Gastric Cancer Brief Screener to Identify Patients for Screening Endoscopy Referral

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Context: Despite the success of gastric cancer screening programs in high-incidence East Asian countries, screening for gastric cancer is not performed in the United States due to its low incidence in the general population. Immigrants from high-incidence countries come to the US carrying the same risk, but do not receive access to the necessary screening to detect cancer in its earliest stages. This results in a high proportion of ethnic minority immigrants presenting with symptoms of advanced-staged gastric cancer when little can be done to improve the chances of survival. *Objective Design:* This study aims to develop a short 5-to-10 item screener that can be used in pre-diagnostic settings to identify high-risk patients for opportunistic screening. In this pilot study, we will create a comprehensive questionnaire with approximately 200 questions related to diet, lifestyle, medical history, ethnicity and immigration history as potential risk factors for gastric cancer. We will assess the validity and reliability of the questionnaire through a series of focus groups and cognitive interviews and trim down the questionnaire based on feedback from these groups. We will then conduct a pilot recruitment to test the feasibility of identifying participants in both clinical and community settings to inform the future scale-up of a larger case-control study. *Setting:* 180 participants will be recruited from Montefiore Medical Center (MMC), Queens Hospital Center (QHC) and several community sites. Participants will be between the ages of 40 and 85, selectively sampled from different ethnic backgrounds. Cases will have been diagnosed with gastric cancer within the past 5 years. Controls will be healthy individuals with no known history of cancer or prior diagnosis that required endoscopic surveillance. *Instrument/Intervention:* We will create a comprehensive questionnaire with approximately 200 questions related to diet, lifestyle, medical history, ethnicity and immigration history. *Results:* We will conduct a pilot case-control study as a field test to inform the scale-up of a larger case-control study. *Conclusions:* Screening for gastric cancer is not performed in the United States due to its low incidence in the general population. Identification of high-risk individuals will enable targeted screening to detect cancer in its earliest stages.

Presentation #29

The B.O.L.D. Initiative: Development of a Patient-Centered Cancer Wellness Program in an Urban, Underserved Community

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Interest in integrative cancer care in the U.S. spans patients of all ethnicities, socioeconomic levels, and medical needs. We describe the development and evaluation of the Bronx Oncology Living Daily (B.O.L.D.) Program, a cancer wellness program founded on the psychosocial needs of patients from one of the most underserved urban communities in the U.S. Methods: Ongoing psychosocial needs assessments began in 2007 reaching 1,450 Bronx cancer patients/survivors (45% Hispanic, 38% African American) identify the following major interests: mind-body therapies (96%), health promotion (72%), creative arts (57%), peer support (53%), volunteering (44%), and counseling (25%). Guided by these needs, the BOLD Wellness Program was launched in 2008 at the Montefiore Einstein Center for Cancer Care (MECCC), supported by internal and external funds and volunteers, under the direction of a health psychologist and medical oncologist. Results: BOLD group offerings include mind-body therapies (e.g., yoga/meditation), fitness/nutrition, and creative expression (e.g., crochet). A 'BOLD Buddy' Program and Psychosocial Oncology Internship provide peer support and counseling services. To ensure cultural responsiveness and sustainability, services are free with travel, stipends available, open to family members, in English and Spanish, at multiple locations, and involve community volunteers/interns. There are up to 15 groups per month, 12 active BOLD Buddies, and 4 counseling interns collectively serving 130 patients/family members per month. Among 922 participants evaluated, 81% were patients of which 35% were on treatment and 55% had a breast cancer diagnosis. Half were African American, 25% were Hispanic, and 95% were female. Most (87%) felt service met their needs and 89% wanted continuation. Referrals came from staff (24%), flyer/media (31%), other patients/friends (25%). Conclusions: The BOLD Program serves as a model for bringing patient-centered, culturally aligned, and sustainable complementary medicine services to an underserved population. Program refinement will focus on enhancing staff referral, and reaching more men.

Presentation #30

Clinical Adverse Childhood Experiences (ACEs) Questionnaire: Implications for Parent-Child Relationship Difficulties and Trauma Informed Treatment

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Context: Much has been written regarding the importance of screening in pediatrics around histories of adverse childhood experiences, a known correlate for poor physical and mental health outcomes throughout the lifespan. Objective Design: We validated the Clinical Adverse Childhood Experiences Questionnaire with the gold standard measure of parent/child attachment relationships, namely the Adult attachment Interview. Setting: We conducted the administration and data collection in an urban setting. Participants were mothers referred for clinical services because they were at risk for maltreating their young children. Instrument/Intervention: The Clinical Adverse Childhood Experiences Questionnaire and the Clinical Child Adverse Childhood Experiences Questionnaire were

developed to determine prevalence compared with the original Aces study. *Results and Conclusion: Prevalence rates were more than 4 times as high as original study and over 80% of mothers presented with a category on the Adult Attachment Interview suggestive of disturbed parent child relationships.*

Presentation #31

Lights, Camera, Play: Preliminary Evaluation of a Mother-Infant Dyadic Video-Feedback Intervention in a Primary Care Setting

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Background: Prior research has emphasized that the environment created by a child's first caregiver(s) profoundly affects virtually every aspect of his or her development. The Center for Child Health and Resiliency (CCHR) serves families in the South Bronx - one of the nation's poorest Congressional Districts. Chronic poverty exposes families to daily stressors that jeopardize stable, affectionate caregiving, thus impeding the child's emotional and physical development. Recent studies highlight that responsive, nurturing care can mitigate this damage. Evidence suggests that short-term, video interventions with mother-infant dyads significantly enhance parental sensitivity and responsiveness. No study to our knowledge has qualitatively evaluated the experience of mothers who participate in a mother-infant dyadic video feedback intervention. Objective: The purpose of this ongoing evaluation is to determine the overall impact, effectiveness, and participant perception of a mother-infant dyadic video feedback intervention composed of six sessions in a primary care setting. Design: 1) comparison of pre- and post-intervention scores on measures of mother-infant interaction adapted from the Global Rating Scale (GRS); and 2) qualitative analysis of exit interviews of women who completed the intervention using a structured, open-ended questionnaire. Participants: Mothers (n=12) of infants, ages 0-18 months at enrollment, and 14 mother-infant dyadic pairs (two sets of twins). Results: Mothers' scores on the GRS after completion of the dyadic video feedback intervention were significantly improved compared to baseline scores. Women reported that seeing themselves interact with their infant and hearing the therapist's feedback allowed them to better recognize their child's cues and respond appropriately. Women implemented changes such as allowing the infant to lead in play, redirecting an infant in a more positive manner, and helping infants learn to communicate by labeling feelings. Conclusions: Preliminary findings suggest that a video feedback intervention is a feasible, well-accepted, and promising treatment option for low-income mothers and is associated with improved maternal responsiveness and stronger maternal-child bonds.

Reproductive Health

Presentation #32

Alternatives to In-Office Follow-up After Medication Abortion

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Mandating in-office follow-up after medication abortion is a challenge to our centers. Even with reminder phone calls, we have many missed appointments, and a substantial loss to follow up rate. Recent studies have shown that phone follow-up, when accompanied by an at-home pregnancy test, is safe and has a high level of satisfaction with patients. Of the 155 medication abortions in 2014 at the Institute for Family Health (IFH) 16th Street, 95 patients (61%) came for in-office follow-up with only one reminder call, 34 patients (22%) required additional staff outreach before they came, and 26 patients (17%) were lost to follow-up despite additional staff outreach. Beginning in the summer of 2015, we have adopted a new protocol for medication abortion follow-up. We now offer follow up via phone or secure electronic messaging, coupled with a low sensitivity home pregnancy test. Patients are asked three simple questions about the signs and symptoms of their abortion, along with the results of the home pregnancy test, and urged to come back to the office if there is any concern for ongoing pregnancy. We will then compare follow up rates over a 12 month time period between this practice and two similar locations, as well as with historical follow up rates. Additionally, we will assess the effect on the number of women choosing long acting, reversible contraception (LARC) after medication abortion with the new protocol.

Presentation #33

Access to the Copper IUD as Post-Coital Contraception: Results from a Mystery Caller Study

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Context: The copper IUD is 99.9% effective as post-coital ('emergency') contraception (PCC), exceeding the effectiveness of the other methods of PCC (levonorgestrel and ulipristal acetate pills.) Previous research has shown that providers rarely offer the copper IUD as PCC and impose restrictions on IUD placement that are not indicated under current medical guidelines. Objective: This study describes access to the copper IUD as PCC and identifies barriers to obtaining this form of contraception. Design: 'Mystery caller' approach to survey primary care, family planning, and ob-gyn clinics. Setting: The study included a total of 199 clinics in nine mid-sized U.S. cities. Clinics were identified for inclusion using the HRSA 340b database, Google search, and the Association of Reproductive Health Professionals' LARC locator tool. Instrument: A single researcher called all eligible clinics assuming the role of a patient seeking the copper IUD for PCC. The researcher used a standardized script to collect information about access to the copper IUD at that clinic, respondent's knowledge of the copper IUD's indication for PCC, and other information volunteered regarding the copper IUD. Main and Secondary Outcome Measures: The primary outcome measure was availability of the copper IUD as PCC at the clinic. Secondary outcome measures included any provision of the copper IUD, awareness of the copper IUD's indication for use as PCC, and the ability to offer accurate information regarding the copper IUD as PCC. Results: All ob/gyn clinics, 87% of family planning clinics, and 68% of primary care clinics offered the copper IUD ($p < 0.001$). About two-thirds (63%) of the family planning clinics, 24% of ob/gyn clinics, and 11% of primary care clinics were aware of the copper IUD's use as PCC ($p < 0.001$). About half (49%) of family planning clinics offered the copper IUD as PCC, while few ob/gyn or primary care clinics did so ($p < 0.001$). Respondents commonly volunteered misinformation about the copper IUD, and medical providers were not significantly more likely than non-providers to provide accurate information regarding the copper IUD's indication for PCC. Conclusion: Access to the copper IUD as PCC is limited and varies depending on the type of

clinic. Substantial gaps exist in knowledge about the use of the copper IUD as PCC, as well as regarding the general medical guidelines for copper IUD placement.

Presentation #34

Contraception Counseling in Two Bronx Pediatric Practices: Results from a Chart Review

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Objective: There is a high rate of unplanned adolescent pregnancy in the Bronx. Many adolescents access contraception-related care through pediatricians. This study offers data from a pre/post intervention chart review that characterizes the counseling and prescription documentation of pediatricians. It is a component of a broader project involving an intervention to increase full scope contraception counseling in two Bronx pediatric practices. Methods: Pulled charts from outpatient visits at two Bronx pediatrics practices, pre and post pilot intervention. 247 charts were pulled from the 'pre' period and 268 were pulled from the 'post' period. 99 charts were manually reviewed from each group, with data collected regarding documentation, coding and prescription practices, as well as patient characteristics. Results: While 46% of teens in the 'pre' group and 48% in the 'post' reported heterosexual activity within the past 2 years, only 19% and 21%, respectively had active contraception prescriptions. Physicians most frequently prescribed oral contraceptive pills, while no prescriptions of the patch or ring were documented. Contraceptive prescriptions were more likely to be documented during 'well child' visits than acute visits. It appears that pediatricians were much more likely to document counseling as 'safer sex counseling' rather than 'contraceptive counseling'. Conclusion: The sample size of this analysis is, unfortunately, too small to deliver statistical differences in mix of contraceptive methods prescribed. It appears that there is no appreciable change before and after the intervention. Notably, a significant proportion of clinicians document contraception counseling in the 'visit note' but do not use ICD-9 coding code for these activities. This could have implications for future methods of assessing the efficacy of interventions. This study is limited by the ability to only ascertain physician documentation rather than behavior directly.

Presentation #35

Integrating Family Planning into Primary Care

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Background : Urban Health Plan (UHP) is a network of Federally Qualified Health Centers providing primary care, and specialty medical care in the South Bronx, and Corona, Queens, New York. In May 2014 UHP was awarded a grant by Public Health Solutions to implement best practices in contraceptive care through site-specific improvement activities, with targeted efforts around pregnancy intention screening and effective contraceptive offer at our Plaza Del Sol Family Health Center site. Methods: Utilizing QI methods: Learning Model, Care Model, and Model for Improvement (PDSA cycles), UHP initiated an interdisciplinary performance improvement team comprised of a provider champion, medical assistant, family planning counselor, practice coach and QI team leader. The population of focus is female patients ages 13-49. The aim is to increase the uptake of effective contraception, with the long term goal of reducing unintended pregnancy. Structured data fields were added to the EMR to prompt screening of patients for pregnancy intention

and document effective family planning method provided. A practice coach was used to support the project. The Team was provided with data reports to drive improvement. Results: Between May 2013 and May 2014, 4932 female patients ages 13-49 were seen for primary care at PDS with 0% screened for pregnancy intention and 11% on an effective method. From June 2014 to the present, 5,986 female patients ages 13-49 were seen for primary care with 86% screened for pregnancy intention and 47% on an effective family planning method of patients' choice. Conclusions: Through screening, education, counseling and provision of family planning services in the primary care setting, female patients obtained a higher level of awareness of family planning options, and were provided with contraceptive methods in support of their individual choices.

Presentation #36

Contraception Counseling in Two Bronx Pediatric Practices: Results from a Survey of Female Adolescents and Pediatric Providers

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Objective: Adolescents may seek contraceptive care from pediatric providers. There is a paucity of data about pediatricians' contraception counseling and prescription. Nor do we know whether adolescents want to access contraception at their pediatric offices. *Methods:* Surveyed resident and attending pediatricians as well as female patients aged 14-20 at two Bronx pediatric practices. Data was collected as baseline prior to piloting interventions designed to increase the proportion of pediatricians who counsel about and prescribe full-scope contraception. *Results:* Of the 96 adolescent patients surveyed, virtually all (96%) did not want to get pregnant in the next year and 83% wanted their clinician to discuss pregnancy prevention. When asked whether each contraceptive was discussed at their visit, the percentage responding 'yes' to the following methods was: 60% condoms, 38% patch, 36% oral contraception, 25-35% abstinence, medroxyprogesterone, EC, implantable, IUD, ring, withdrawal and/or dual protection. 70% wanted more contraception information, preferably in the form of a handout. Thirty-seven percent of the adolescents had never been sexually active with a male partner. Those adolescents who were sexually active were older than the group overall (median age 17.9 years vs 16 years). Fifty-two of the 63 pediatric providers invited to participate responded; 48 were eligible. The vast majority (96%) agreed that discussing and offering the range of contraceptives is within a general pediatricians' scope of practice. In the past 6 months, 70% initiated prescription contraception, 45% and 19% referred for IUD or implantable insertion (respectively). When discussing contraception with a female adolescent, what follows is the percent who reported always or frequently discussing the following methods: 100% condoms; 96% oral contraception; 83% dual protection; 79% IUD; 73% medroxyprogesterone; 68% abstinence; 66% EC; 55% ring and/or patch; 45% implantable. *Conclusions:* These adolescents want their pediatricians to discuss contraception. Pediatricians believe contraception provision is within their scope of practice. If contraception was discussed at a visit, it appears that adolescents and pediatricians differ in their perception or recollection about which methods were discussed.

Presentation #37

Enhanced Reproductive Health Training for Family Medicine Residents

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Purpose: RHEDI, Reproductive Health Education in Family Medicine, offers technical assistance and funding to family medicine residency programs to support integrated opt-out abortion and reproductive health training for residents. This study assessed the impact of the women's health rotation with enhanced training through RHEDI on residents' reproductive health experience and skills at 13 of those residency programs over an 18 month period. Methods: Pre and post surveys were administered online to PGY2 residents at the beginning and end of their RHEDI training experience. Surveys addressed topics including experience with contraception, ultrasound, abortion, self-assessed competency in medication abortion, manual vacuum aspiration and electric vacuum aspiration, as well as other experiences in reproductive health care. 146 matched pre and post surveys from residents in RHEDI programs, a response rate of over 80%, were analyzed in SPSS. Descriptive statistics were generated and statistical tests were used to assess changes from pre to post. Results: After the RHEDI rotation, residents had increased their level of experience in contraception provision, ultrasound, aspiration, medication abortion, and management of early pregnancy loss (miscarriage). As well, their self-rated competency in all three types of abortions had increased. Experience with LARC methods increased notably, with the percentage of residents who had inserted IUDs and hormonal implants rising from 70% to 99%, and 49% to 81%, respectively. Residents who had performed any abortions increased from 16% to 80%. Conclusions: Integrated opt-out training in reproductive health, with an emphasis on abortion, is an effective way to increase residents' experience and self-rated competency in these types of patient care. Increasing the number of family medicine residency programs that offer this training could help prepare family doctors to meet their patients' needs for reproductive health services.

Resident Education

Presentation #38

Breaking Through the Silos: Merging Clinical and Insurance Data for Population Health Management in Two Family Medicine Teaching Practices

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Context: The disconnect between clinical and insurance provider assignment is a barrier to effective care coordination and may impede pursuit of clinical and population health objectives. This disconnect is particularly challenging for residency training programs. Objectives: Conduct Proof of Concept Data Merge, Identify Common Patients, Identify Useful Analysis Perspectives, and Pilot Case Management Process Workflow Data Merged: Teaching Health Center (FHC and Williamsbridge) clinical data (with clinical PCP assignment) with Care Management Organization (CMO) insurance data for CMO enrolled Patients (Risk pool, Treo Resource Use Algorithms, and Case Management System Data) Results: Of 22,043 patients treated at FHC and WB in the last 18 months, 13,836 (63%) were enrolled in CMO risk pool. The CMO database correctly identified the primary care site for approximately 85% of these patients. 1.55 physicians had greater than 100 patients in their clinical panels. Of patients attributed to these physicians by the insurance carrier, approximately 40%

(range 17-77%) were attributed to the correct clinical PCP. 2. Filtering patients by diagnostic and spending criteria allowed the identification of patients who might be candidates for case management. PCP review of these lists reveals patients who are appropriately receiving case management services, as well as some who might be receiving case management unnecessarily, and others who are not receiving case management who might benefit from such services. Conclusions: Merged clinical and insurance data can be analyzed to identify patients appropriate for case management engagement. The pool of potential patients for each physician averages less than 30 patients, making physician review a feasible task and a valuable teaching exercise for resident physicians. Addition of clinical problem lists and other clinical and insurance data could make the merged data set more useful. This process could overcome current problems with patient attribution in teaching practices and allow for increased resident physician engagement with case management services.

Presentation #39

Resident Documentation of Social Determinants of Health: Effects of a Teaching Tool

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Background: Social determinants of health (SDH) significantly impact the health of children, and thus, screening for SDH is an important component of the primary care visit in underserved and poverty-stricken communities. Resident medical curriculum should include how to effectively and comprehensively inquire about SDH. A mnemonic, 'IHELLP,'- Income, Housing, Education, Literacy, Legal Status, Personal Safety- has been used to assist in eliciting a social history which includes these SDH. However, there is limited research on how an educational intervention incorporating this tool can impact resident assessment of SDH. Objective: To assess the impact of a two phase educational intervention using (1) the 'IHELLP' mnemonic alone and (2) in conjunction with visual reminders, on resident physician documentation of SDH. Design/Methods: A two-phase quasi-experimental intervention was implemented with 8 residents over a 3 month period: phase 1 (P1) entailed a 3 hour teaching module describing the 'IHELLP' mnemonic, SDH content, and relevant community resources; phase 2 (P2) included posted visual reminders on a 2 x 4 card in all resident clinic rooms and laminated pocket cards for residents. Charts were reviewed, using a 'yes/no' checklist, assessing the residents' documentation of SDH. Charts were assessed at baseline (as a control) and after each intervention. Pre- and post- intervention comparisons were made using chi square analyses. Results: A total of 357 charts were reviewed: 101 charts at baseline, 143 charts after P1, and 113 charts after P2. The average age of patients was 47.2 months; 55% female, 45% male. As compared to baseline, residents were significantly more likely to document asking about WIC benefits after P1 (40.5% vs 57.6%, $p<0.01$) and after P2 (40.5% vs 60.2%, $p<0.01$); they were also more likely to ask about food stamps (14% vs 28%, $p<0.01$) and about financing of current housing (4% vs 12.6%, $p<0.05$) after P2. There were no differences in documentation of education, legal status, literacy, and personal safety issues. Conclusions: Implementation of an educational teaching module using 'IHELLP' along with visual reminders enabled residents to document SDH in concrete services such as benefits and housing. Further studies should be done to evaluate effective teaching methods to assist residents in eliciting other, more sensitive, social determinants of health such as education, legal issues, and personal safety.

Presentation #40

The EMR in Residency: A Tool and a Teacher

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Electronic Medical Records (EMR's) are ubiquitous not only in clinical practice, but also in residency education. The EMR has become a means of teaching residents. Faculty need to be aware not only of how to teach an EMR, but also how to use it effectively in their curricula. Central to our curricula on the EMR is an experiential focus, starting at orientation. The utility of the EMR to teach varies with the lesson, and different EMR methods have proven helpful. This adaptability allows our curricula to be dynamic and responsive to the needs of clinical documentation. Our quality review data suggests that our residents achieve quality documentation and have satisfaction with the EMR.

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