



Abstracts from the 2011 NYC RING Convocation of Practices

Tuesday April 12, 2011



Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

www.nycring.org



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NYC RING

New York City Research & Improvement Networking Group

ABOUT US

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.

WHAT IS A PRACTICE-BASED RESEARCH NETWORK (PBRN)?

A voluntary association of practicing clinicians collaborating to improve quality-of-care through research or quality improvement in their offices.

OUR UNIQUE GOAL

To focus on the issues of underserved urban communities through research initiatives and quality improvement projects.

CRITICAL ELEMENTS OF NYC RING PROJECTS

- 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

PARTICIPATION

We welcome both *new member practices* and *collaborators* working on research topics appropriate for the practice-based setting.

NYC RING TEAM

Diane Mckee, MD MS
NYC RING Director
Diane.mckee@einstein.yu.edu

Paul Meissner, MSPH
Network Development
Pmeissne@montefiore.org

Claudia Lechuga, MS
Network Coordinator
Claudia.lechuga@einstein.yu.edu

Albert Einstein College of Medicine
1300 Morris Park Ave, Mazer 405
Bronx NY 10461

Please visit our website at www.nycring.org to learn about our goals and projects.
Contact NYC RING: nycring@einstein.yu.edu

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

Montefiore Medical Group

- Bronx East
- Castle Hill
- Comprehensive Family Care Center (CFCC)
- Comprehensive Health Care Center (CHCC)
- Co-op City (Bay Plaza)
- Family Care Center (FCC)
- Family Health Center (FHC)
- Grand Concourse
- Fordham Family Practice
- Marble Hill Family Practice
- University Avenue Family Practice
- West Farms Family Practice
- Williamsbridge Family Practice
- South Bronx Health Center for Children and Families

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

2011 NYC RING Convocation of Practices

“Transforming Primary Care:
Perspectives on Implementation of New Models of Care”

Tuesday April 12, 2011
Agenda

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

4:30-6:00pm **Welcome and Keynote Address**

Peter Selwyn, MD MPH

Chair Montefiore Medical Center Department of Family and Social Medicine

Perry Dickinson, MD

President Society of Teachers of Family Medicine, University of Colorado Professor

Michael Erikson, MSW

VP of Primary Care Services for Group Health Cooperative, Seattle, WA

Bruce Soloway, MD

Vice-Chair Montefiore Medical Center Department of Family and Social Medicine

6:30-7:00pm **First Round of Poster Presentations**

Authors of **even**-numbered posters stay by their poster

7:00-7:30pm **Second Round of Poster Presentations**

Authors of **odd**-numbered posters stay by their poster

Chronic Diseases

Abstract 1**The Effect of Pain on Treatment Retention and Heroin use in an Office Based Buprenorphine Treatment Program**

Aaron D. Fox, M.D., Nancy L. Sohler, Ph.D., M.P.H., Angela Giovanniello, Joanna Starrels, M.D., M.S., Yuming Ning, Ph.D., Chinazo O. Cunningham, M.D., M.S.

Contact: adfox@montefiore.org

Background: Clinical guidelines cite chronic severe pain as a relative contraindication to buprenorphine treatment. Data supporting these recommendations is lacking. To examine the association between pain and buprenorphine treatment outcomes, we compared the proportion of treatment failures in opioid dependent patients with and without pain who received office based buprenorphine treatment.

Methods: We conducted a longitudinal cohort study of opioid users who initiated buprenorphine treatment at an urban community health center. Participants were interviewed at baseline, and 1, 3, and 6 months after initiating buprenorphine treatment. The primary outcome was retention in treatment at 6 months. The secondary outcome was heroin use over 6 months of follow-up. We used multivariate regression models to test whether these outcomes were associated with pain at baseline or with persistent pain throughout treatment.

Results: Of 84 participants, 51 (61%) reported pain at baseline and 31 (37%) reported persistent pain throughout treatment. The groups with and without persistent pain differed on a number of factors, including history of injection drug use (68% vs. 42%, $p < .05$) and depressive symptoms (81% vs. 55%, $p < .05$). At 6 months of follow-up, 48 (57%) participants were retained in treatment and 20 (23%) had ongoing heroin use.

Adjusting for injection drug use and depressive symptoms, there was no difference in treatment retention at 6 months between those with and without persistent pain (OR = 1.32, 95% CI: 0.32 – 5.43) or those with and without baseline pain (OR = .89, 95% CI: .21-3.79).

Adjusting for baseline heroin use, injection drug use and depressive symptoms, there was no difference in heroin use over 6 months between those with and without persistent pain (OR = .95, 95% CI: 0.19 – 4.67) or those with and without baseline pain (OR = .58, 95% CI: .11 – 3.03).

Conclusions: Nearly two-thirds of participants reported pain at baseline and over one-third experienced persistent pain. Despite more risk factors for treatment failure, patients with pain had similar substance abuse treatment outcomes to those without pain. Our study demonstrates that opioid dependent patients with pain can achieve treatment success with buprenorphine therapy.

Abstract 2

The Perception of Poverty Among Primary Caregivers of Children with Asthma in an Urban Setting

Scott E. Lloyd, M.A., Jonathan M. Feldman, Ph.D.

Contact: scottelloyd@gmail.com

Background: Asthma is a chronic health concern for parents and health care providers in urban centers such as the Bronx, New York. Low Socioeconomic Status (SES) is a factor that has been linked with poor health outcomes. The Perception of Poverty Measure (PPM) provides a valuable tool for capturing the psychological impact on individuals living in poverty.

Objective: The purpose of this study was to examine the impact of Parental Perception of Poverty (PoP) on childhood asthma morbidity in an inner-city asthmatic population.

Methods: A total of 121 primary caregiver-child dyads of Puerto Rican, African American, Afro-Caribbean or Anglo-American descent were administered separate batteries of self-report questionnaires related to six outcome measures. Data were analyzed based on three perceived poverty groups: live well (n=50), live check-to-check (n=53), and live poor (n=18). Children were all between 7 and 15 years of age. Parental perceived poverty and children's functional asthma morbidity were primary measures. Secondary measures included child sick visits due to asthma, emergency department utilization, and quick relief medication use. Data were also collected on Forced Expiratory Volume during the first second (FEV1), median family income, and medication regimen. A five-week follow up was conducted to track use of quick relief medication.

Results: There was a significant effect of PoP on functional morbidity during the past year after controlling for asthma medication regimen and median family income ($p < .01$). Bonferroni post hoc tests showed that people who reported living poor ($M=2.40$, $SD=0.78$) had worse functional morbidity score than those who lived check to check ($M=1.79$, $SD=0.79$, $p=.013$) and those who reported living well ($M=1.51$, $SD=0.72$, $p<.001$). Significant between-group differences were not found on secondary outcome measures.

Conclusions: The PPM may be a useful tool for allowing providers to obtain a subjective estimate of how SES affects the management of chronic health conditions such as asthma. Future research is needed to determine the extent to which PoP is correlated with other psychosocial processes such as learned helplessness and depression.

Abstract 3

Blacks and Exacerbations on LABA vs. Tiotropium (BELT)

Montefiore Team: Donald Raum, M.D., Asif Ansari, M.D., Manuja Mathur, M.D., Paul Meissner, M.S.P.H., Claudia Lechuga, M.S.

Central Team: Elliott Israel, M.D., Michael Wechsler, M.D., Michael Pencina, M.D., Barbara Yawn, M.D., Wilson Pace, M.D., Shamsah Kazani, M.D.

Contact: claudia.lechuga@einstein.yu.edu

Blacks bear a disproportionate burden of asthma morbidity and mortality. In its 2005 report on ethnic disparities in health care, AHRQ identified hospital admissions for asthma as the second largest disparity in quality of health care for Blacks vs. Whites. Long-acting beta-agonists (LABAs), a popular treatment option for asthma, are in a class of drugs acting at ADRB2, which have been associated with rare loss of long-term asthma control and increased serious adverse outcomes including death and respiratory failure, even when used with ICS. The risk appears four to five fold greater in Blacks than non-Black patients with asthma.

Comparison of studies with LABA/ICS in Blacks vs. studies where Blacks were a small minority suggests that Blacks may have much less benefit than other racial groups. Additionally, recent data (Wechsler 2009) suggest that a polymorphism at the 16th position of the ADRB2 gene identifies a group of Blacks (those homozygous for arginine (Arg16Arg)) in whom the response of adding a LABA to an ICS is further diminished. This polymorphism is present in ~20% of US Blacks.

In order to address the resulting knowledge gaps, a study is proposed to determine, in a one year practice-based, real-world, randomized, prospective, parallel group, longitudinal comparative effectiveness trial with the clinically important primary outcome of asthma exacerbations, whether in self-identified Black patients with asthma, treatment with LABA/ICS is superior to use of a non- β -adrenergic bronchodilator (tiotropium) combined with ICS (Tio/ICS). The study will also aim to determine, whether in the 20% of self-identified Black patients with asthma bearing Arg16Arg of ADRB2, treatment with LABA/ICS is superior to use of a non- β -adrenergic bronchodilator combined with ICS.

Abstract 4

Improving Diabetes Outcomes through Integrated Care Management and Case Management

Cynthia Kim, L.C.S.W.

Contact: ckim@institute2000.org

Context: This project is being conducted as a continuous quality improvement project looking at the relationship between improved self-management and health outcomes for patients with diabetes.

Objective: Objectives included the following: Improve health outcomes for traditionally underserved patients diagnosed with a chronic illness (i.e. Diabetes), integrate aspects of care management with case management services provided to underserved patients, and increase understanding of improved self-management of chronic illness as a function of increased efforts to provide psychoeducation, access to supportive services, and increased adherence with medication management and attendance to visits with providers

Setting & Participants: This project is being conducted within a case management program at the Sidney Hillman Family Practice, one of many program sites within the Psychosocial Services Department of the Institute for Family Health. Participants are patients with diabetes who are seen for case management services within the aforementioned program.

Intervention: Intervention tools were created to be shared with patients during case management visits, including patient-friendly handouts on their illness, self-monitoring tools, and a brief questionnaire to assess adherence with visits, medications, and confidence in efficacious self-management of their illness.

Results: Preliminary results revealed an increased in adherence with visits to providers and with medications, improved confidence in self-management, and positive health outcomes including lowered A1C values. Results are still pending for additional health outcomes (i.e. cardiometabolic indicators such as blood pressure and cholesterol lab values).

Conclusions: Integration of care management into case management visits provided a viable venue to enhance patient education and intervention around improved self-management of a chronic illness.

Abstract 5

Putting Guidelines into Practice: Improving Documentation of Pediatric Asthma Management Using a Decision-Making Tool

Alan Shapiro, M.D., F.A.A.P., Delaney Gracy, M.D., M.P.H., F.A.A.P., Wendy Quinones, B.S.N., M.S.N., C.P.N.P., Jo Applebaum, M.P.H., C.P.H., Ariel Sarmiento, M.P.H., C.P.H.

Contact: ashapiro@montefiore.org

Context: Residents of public housing, the family shelter system, and the South Bronx have among the highest pediatric asthma rates in New York City. Improving asthma care and closing disparities in outcomes require translating complex guidelines into primary care practice, where most asthmatic children receive care.

Objective: To assess improvement in documentation of asthma indicators using the Asthma Toolbox, an asthma decision-making tool developed in accordance with National Asthma Education and Prevention Program Guidelines.

Design: Retrospective chart review, using cross-sectional, independent random samples. Chart reviews were conducted for 1-year periods before and after implementation, and after revision reflecting 2007 guideline modifications.

Setting: Two inner-city Federally Qualified Health Center programs providing pediatric primary care to housed and homeless populations.

Participants: A total of 1246 patients aged 6 mo–18 years with at least 1 asthma visit at a community health center using paper records (n=600) or a mobile medical program serving family homeless shelters using an electronic health record (EHR; n=646).

Intervention: Implementation of the Asthma Toolbox incorporated into paper encounter forms and embedded in the EHR, and provider training on guideline-based, pediatric asthma assessment and management.

Outcome measures: Documentation of a subset of asthma severity/control measures, emergency department visits, hospitalizations, and percentage of persistent asthmatics prescribed controller medications.

Results: Documentation of each asthma indicator increased significantly after implementation (chi-square tests; $P < .001$ all comparisons) for both programs. Documentation of severity/control increased from 25.5% to 77.5% in paper records and from 11.7% to 85.1% in the EHR ($P < .001$). Increases were sustained after Asthma Toolbox revision for all indicators. The percentage of patients with persistent/uncontrolled asthma prescribed controller medications reached 96%–97% in both programs.

Conclusion: Use of an asthma decision-making tool significantly increased documentation of pediatric asthma management among providers working in high-disparity, urban primary care settings.



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Abstract 6

Do Caregivers of Children With Persistent Asthma Know How to Use Metered Dose Inhaler Plus Spacer Device?

Yu Cao, B.S., Jacquelyn Dorsky, B.S., Marina Reznik, M.D., M.S.

Contact: mreznik@montefiore.org

Abstract 7

Intensive Case Management for People with Poorly Controlled Diabetes at Two Family Medicine Residency Practices - Interdisciplinary Care and Education

Victoria Gorski, M.D., F.A.A.F.P., Fabienne Daguilh, M.D., Sandra Barnaby, R.N., M.P.H., Amanda Spray, M.A., Lucille Ferrara, Ed.D., F.N.P.

Contact: vgorski@montefiore.org

Based on principles underlying the Chronic Care Model and the Patient-Centered Medical Home, interdisciplinary teams focused on people with poorly controlled diabetes have been evolving at Montefiore's Family Medicine Residency Practices, the Williamsbridge Family Practice and the Family Health Center. Initial team development was supported by the American Association of Medical Colleges Chronic Care Collaborative. 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 rely 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 A1Cs>9. Over time, the teams have incorporated a variety of learners, including residents in family medicine, health psychology students and doctor of nursing practice students. The intensification process has been able to generate both short and long term improvements in A1C. In addition, an improvement in reported quality of life has been demonstrated for a cohort of patients at Williamsbridge. Next steps at Williamsbridge include exploring steps to limit or prevent "backsliding" and at FHC next steps include furthering implementation of group medical visits and improving outreach.

This work owes its success to team members: Jennifer Leone, Tanya White-Davis, Freddy Baez, Ibis Castro-Katzman, Alfonsina Perez, Claudia Robinson, Anupama Kotay, Abigail Batchelder, Jennifer Egert, Eliana Korin, Director of Behavioral Science, site administrators Blanche Doati and Sheila Yates, and from the CMO: Sheila Felleman and Anne Meara.

Abstract 8

An Effective Primary Care HIV/AIDS Health Literacy Tool: The Brief Evaluative Health Knowledge Action (BEHKA)

Norma Cordero-Padilla, Eric Machicote, B.A., Robert Beil, M.D., Angel Giovanniello, Pharm. D., Peter Meacher, M.D.

Contact: ncordero@montefiore.org

Purpose: Patients with low health literacy are at greater risk of misunderstanding treatment recommendations, having problems in accurately taking prescription medications, and self-reporting lower health status and poorer health outcomes. Consequently, they have a 52 percent greater risk of being hospitalized. It is estimated that non-adherence, or incorrect dosing, results in 125,000 deaths annually and costs an estimated \$100 billion in treatments and lost productivity. Limited health literacy in HIV/AIDS infected-individuals has been linked to lower CD4 cell counts and higher blood serum viral load. This poster will demonstrate the effectiveness of a health literacy screening tool, its ability to identify patients needing additional health education and will improve patient outcomes by empowering patients with a better understanding of disease stages, lab results and medication regimens.

Methodology: Patients were assessed using the BEHKA-HIV screening tool during their ancillary and primary care appointments. The first section of the assessment included questions pertaining to the patients' knowledge of CD₄ cell counts and the definition of a viral load. The second section of the assessment asked the patients whether they agreed or disagreed with certain statements.

Example Statements:

1. "I don't take my meds when they make me feel bad"
2. "I don't take my meds when I am too tired".

Patients will be evaluated every six months to gauge their understanding of lab results (CD₄ cell and viral loads) and medication regimens.

Results: Twenty- three percent (23% n=32) of the patients evaluated had a below average health literacy score. Fourteen percent (14% n=20) of the patients answered the questions marginally. Sixty -three percent (63% n=90) of the patients had a reasonable understanding of their lab results and medication regimens.

Conclusion: The BEKHA-HIV tool helped to systematically identify problems with literacy levels in our patients. The total scores showed a reasonable literacy level of 63% throughout the network, however when the scores were tallied from the first section of the screening tool it revealed a significantly different view of the literacy level of the patients. Thirty-seven percent (37%) could not accurately describe basic labs (CD₄ cell count and viral load) and list their medications. CD₄ cell count and viral load are considered basic HIV education markers for our patients and 37% of our patients lack an understanding of this important health information.

References: *Health Literacy Practices in Primary Care Settings: Examples from the Field*

Sharon E. Barrett, Jennifer Sheen Puryear, and Kathie Westpheling
January 2008

Abstract 9

A Cross Sectional Telephone Survey of 64 Patients Who Had Percutaneous Lumbar Discectomy in the Past 6 Years

Thaddeus Lynn, M.D., Ian Yan, M.D., Douglas Reich, M.D.

Contact: thaddeuslynn@aol.com

Background: Discogenic low back pain continues to be a primary cause of health care expenditure in the United States of America. This pain may be either compressive or noncompressive to the nerve roots following intervertebral disc herniation. Non-compressive disc herniation is more common and requires non-invasive management; however, some patients do not respond to non-invasive management and have refractory pain. Percutaneous Lumbar Discectomy (PLD) with a probe is a minimally invasive and extra-pedicle approach that enables selective, quantifiable extraction of herniated nucleus pulposus without intraspinal canal disturbances. In the past 6 years, we have performed more than 70 PLD procedures using Dekompressor probe, in patients who have chronic low back pain secondary to a contained disc herniation refractory to noninvasive therapies. All patients reported an immediate pain reduction of greater than 80 %.

Objectives: This cross-sectional survey obtains outcome data post Percutaneous Lumbar Discectomy in a cohort of 64 consecutive patients.

Method: A targeted questionnaire assesses four areas: (1) pain relief; (2) physical function; (3) opioid medication consumption; and (4) patient satisfaction. The Oswestry Disability Index (ODI) is used as a specific outcome measure to detect change in physical function after the PLD. The survey is administered by telephone after an invitational letter is sent explaining the study. Upon completion of the survey, participants will receive \$25.00.

Data Analysis: The pain relief data will be recorded via verbal numeric pain scale 0-10 based on the Visual Analog Scale (VAS). The efficacy of the procedure will be analyzed with Kaplan-Meier Survival Curve. Functional evaluation will be tabulated with activities of daily living. In addition, the ODI will be used as a specific outcome measure to detect post-treatment change in physical function, with results expressed as a percentage of physical disability. Opioid consumption will be measured as a percentage increase or decrease. Patient satisfaction will be tabulated via a scale of 1-3 where 1 = unsatisfactory, 2 = satisfactory and 3 = excellent satisfaction achieved by the procedure.

Health Promotion

Abstract 10**Heart Disease Education and Prevention at the Geel Clubhouse**

Anne Katz, B.A., Vladimir Kaplinskiy, B.S., William Jordan, M.D., M.P.H., Gladys Valdivieso

Contact: anniebkatz@gmail.com

Context: The life expectancy of people with severe mental illness is 25 years less than the national average, mostly due to cardiovascular disease. Compared to the general population, people with severe mental illness experience twice the rate of diabetes, dyslipidemia, hypertension, and obesity, but are less likely to receive medical care.

Objective: Provide health education on heart disease for people with severe mental illness.

Design: Family medicine clerkship students from Albert Einstein College of Medicine use the community-oriented primary care model to provide services throughout the Bronx. Each month, a pair of students provides twice weekly health education on a particular theme to community members with severe mental illness. In February 2011, based on an initial qualitative assessment of participant interests and needs, five sessions were created and delivered on heart disease risk and prevention. Verbal feedback was continuously elicited to refine the sessions, and an anonymous survey during the final session will guide future revisions.

Setting: Geel Clubhouse in Bronx, NY.

Participants: Education was open to all Geel Clubhouse members with a total of 15 participants, ranging from 4-11 participants per session.

Results: Based on a COPC model, students formulated and deployed a 5-session health education intervention on heart disease risk and prevention. Session content (and format) included: (1) an overview of modifiable risk factors (poster); (2) basic nutrition (pamphlet); (3) diet and hypertension (24-hour dietary recall); (4) exercise promotion; and (5) stress reduction.

Conclusions: Medical students can use the COPC model to provide much-needed health education to people with severe mental illness in a community setting.

Abstract 11

Promoting Breastfeeding Amongst Family Physicians

Gina Basello, D.O., Aamira Tahir, M.D., Isabella Park, D.O., Maritza Jerome, D.O.

Contact: gbasello@jhmc.org

Breastfeeding has been long recognized as the optimal way of feeding an infant due to the proven health benefits to both infants and mothers. Some of the direct benefits to infants include stimulating the growth and motility as well as enhancing the maturity of the gastrointestinal tract. Other benefits to the infant include antimicrobial activity which lowers the rates of diarrhea, respiratory illnesses, otitis media, and urinary tract infections. Breastfeeding has positive benefits to the mother as well. Those who decide to breastfeed have reduced risk of breast, ovarian, cervical, and endometrial cancers. Breastfeeding also aids in the delay the return of fertility, space subsequent pregnancies, and helps the mother's body return to its pre-pregnancy state faster.

Studies have shown physicians, including residents, in family medicine, pediatrics, and OBGYN do not receive adequate training in breastfeeding counseling. Family physicians are in a unique position that can provide lasting breastfeeding counseling and education because they provide prenatal and postnatal care for the mother as well as health care for the baby. This allows for many opportunities to monitor longitudinally prompt breastfeeding education, initiation, continuity, and counseling.

The purpose of our study is to evaluate the comfort level and knowledge base of our family medicine residents and faculty attendings. Assessment will be made with a pre-test questionnaire before teaching modules and afterwards with a post-test questionnaire. The teaching modules consist of a grand round lecture given by the Department of Health and two noon conference lectures given by lactation specialists and the researchers. With the help of an epidemiologist, the pre-test and post-tests were analyzed and revealed a significant improvement in scores ($t= 2.16$, $p < 0.04$).

The second part of this project, which is still in progress, is a chart review study set in the residency program's clinic that entails a performance improvement analysis of breastfeeding counseling. Charts will be reviewed of newborn and 4-month visits prior to the teaching modules to examine documentation of breastfeeding initiation, continuity, counseling, and encouragement. Another chart review will be done post-teaching modules newborn and 4-month visits to evaluate any change in the documentation of breastfeeding.

Abstract 12

Post-Partum Education: Safe Infant Sleep

Carolyn Sy, MSIII, Bonnie Crouthamel, MSIII, Maria Santos, M.D., Gladys Valdivieso

Contact: carolyn.sy@med.einstein.yu.edu

Context: Sudden Infant Death Syndrome (SIDS) is the leading cause of death of babies aged 1 month to 1 year. While the actual cause of SIDS is unknown, it has been strongly associated with unsafe sleep practices, such as placing babies on the stomach to sleep. Minority populations are found to have increased SIDS rates, with African American babies being twice as likely to die from SIDS as white babies. In the Bronx where there is a large minority population, only about half of babies are placed on their backs to sleep. Previous studies have shown that in-hospital postpartum education impacts parents' choices for sleep position.

Objective: To educate postpartum patients about SIDS, its relationship to safe sleep practices, and to promote safe sleep to reduce the Bronx SIDS rate.

Setting: The post-partum floor at Weiler Hospital.

Design & Intervention: The design of the intervention utilized Knowles' Adult Learning Principles to maximize impact. Medical student educators performed one-on-one in-room interventions with postpartum patients and assessed their knowledge about SIDS and safe sleep. Using a poster as a visual aid, students defined SIDS, linked safe sleep to SIDS prevention, assessed the parents' sleep plan at home, and provided simple tips for safe infant sleep. The patients participated in an interactive game to identify unsafe sleep practices. A flier containing the material was distributed for reinforcement.

Results: 95 patient interventions were conducted, twelve of them in Spanish. The intervention was well received, with patients asking for extra flier copies and expressing intention to display the flier in the baby's room.

Conclusions: More data and time are needed to determine the impact of the intervention on the target population. The project can be improved by implementing formal follow up to assess the intervention's effectiveness, expanding the number of languages in which the intervention is offered and including other community members in the Intervention.



Abstract 13

10 Steps to a Breastfeeding Friendly Medical Practice

Miriam Wood, B.A., Donna Muller, Marisa Mourgues

Contact: mwood@institute2000.org

Context: Breastfeeding rates remain low in the US, despite research identifying benefits for mothers and babies and endorsements by health organizations.

The Baby Friendly Hospital Initiative (BFHI) is a program developed to improve breastfeeding rates within hospitals. However, there is not an official program in the US that addresses improving breastfeeding rates in out-patient medical facilities.

Objective: The “10 Steps to a Breastfeeding Friendly Medical Practice” was developed to fill this gap and provide a framework for our organization, and a model for others, for increasing breastfeeding rates among patients.

Design: The Institute for Family Health (IFH) is a multi-site Federally Qualified Community Health Center that oversees primary care facilities and community programs in Manhattan, the Bronx and the Mid-Hudson Valley.

A ten-step program was created by the IFH Breastfeeding Committee. This program is based on the Baby Friendly Hospital Initiative, as well as UNICEF UK’s Seven Point Plan for Sustaining Breastfeeding, and a wide body of literature.

Our goal is for staff and patients to receive accurate information about breastfeeding and for every pregnant and parenting woman to have a supportive breastfeeding environment.

Instruments & Interventions: Our Committee has come up with a 10-step plan designed for implementation in an out-patient medical setting.

Results: It was critical to develop a Breastfeeding workgroup, including key staff, particularly medical providers from each field acting as champions within their sites. Additionally, we need to involve and educate staff at every level for maximum impact. One important step was introducing a Breastfeeding & Lactation policy organization-wide.

Conclusion: More work on implementation and evaluation needs to be done. However, getting our organization to the point where we have been able to launch such a large-scale policy and practice shift has already been a tremendous success.

Abstract 14

Integrative Health in a Community Health Center Setting

Deborah Lester, L.M.S.W., Patricia Peralta

Contact: debbie.lester@urbanhealthplan.org

Background: In 2007, the Canyon Ranch Institute Life Enhancement Program (CRI LEP) was created to transfer the best practices of Canyon Ranch to underserved communities in order to prevent, diagnose, and address chronic diseases through an integrative health approach. Urban Health Plan (UHP), a network of federally qualified community health centers based in the South Bronx and Queens, was the first pilot program, and customized the CRI LEP to its adult patient population. UHP facilitated four cohorts of patients through the program.

Objective: To empower adult patients to embrace a life of wellness through a culturally proficient, interdisciplinary, and proactive approach focusing on the 4 dimensions: physical, mental, emotional and spiritual.

Setting: UHP's main primary care site, El Nuevo San Juan Health Center in the South Bronx.

Participants: 56 adult patients with pre-chronic or chronic illness referred by their primary care provider.

Design: The CRI LEP at UHP is offered twice a week for 6 weeks and includes guided fitness, stress management, nutrition and relaxation education. Follow-up support includes telephone support, monthly reunions, and a seasonal newsletter. Data is collected from the EMR during four evaluation periods (pre-program, post-program, 3-months post-program and 12-months post-program).

Measures: Knowledge Attitudes Behavior Questionnaire, Patient Health Questionnaire (PHQ-9), lipid screening (cholesterol, HDL, LDL, triglycerides), C-reactive protein/ultra, fasting blood sugar, Hemoglobin A1C, pulse, blood pressure, weight, BMI, physical assessment, clinician EMR notes, facilitator evaluations, self-report, frequency of exercise, and attendance at reunions.

Results: Participants with hypertension or in the pre-hypertensive range prior to the start of the program experienced an average drop in blood pressure of 12/7.5 mm Hg; those without hypertension experienced an average drop in blood pressure of 7.8/2.3 mm Hg. Participants lost an average of 3.37 pounds, with the highest individual weight loss being 11 pounds. Depression scores dropped an average of 6.1 points (on a scale of 0-27 points). Qualitative analysis revealed that participants developed the desire and abilities to learn more about their health.

Conclusion: With noted improvements in depression and health literacy, trends suggest that primary care that includes an integrative health program linguistically and culturally tailored to the population, can benefit adult patients with chronic illness.



Abstract 15

ZumbaBronx: Integrating Physical Activity in the Patient-Centered Medical Home

Michelle Vaca, M.D., Harini Kumar, M.D., Rose Guilbe, M.D., Renee Shanker, M.P.H.

Contact: mvaca@montefiore.org

There is a great need for structured fitness training programs that are accessible to residents of underserved neighborhoods, where resources are scarce but disease is prevalent. Primary care practices, which are located in underserved areas, are in an opportune position to play a critical role in designing an effective intervention that can be integrated into the patient centered medical home. ZumbaBronx is the 12 week intervention that has been structured to foster partnerships amongst patients, health educators, physicians and community health centers. Health educators, physicians and community members have worked together to design and choreograph the ZumbaBronx intervention. By piloting and replicating a well defined, intervention, health care providers and health educators have partnered with the primary care center and community members to implement team-based care. In the future, community members will attend leadership workshops, advocacy training, and job training to build the fitness instructor work force. The ZumbaBronx Intervention has identified the effective partnership between health educators, physicians and community members in order to provide and sustain a 12 week intervention. Evidence from the literature and experience from the salsa curriculum illustrate the function of an exercise community in engaging community members in promoting healthy lifestyle changes. The data, from the intervention, demonstrates that the target audience is women. A post intervention survey is being administered to review the sustainability of improved physical activity and improved health outcomes once a patient graduates from ZumbaBronx.

Mental Health

Abstract 16

Reducing Distress and Improving Treatment Adherence in Type 1 Diabetes: Feedback from an Open-Phase Pilot

Sabrina Esbitt, B.A., Molly Tanenbaum, B.A., Havah Schneider, M.A., Persis Commissariat, B.A., Elyse Kupperman, Jeffrey Gonzalez, Ph.D.

Contact: sabrina.esbitt@gmail.com

Context: Depression has consistently been found to be more prevalent among individuals with diabetes; recent meta-analyses suggest a 15-20% prevalence, approximately twice that of the general population. A large body of literature has noted the association between depression and poor diabetes outcomes, including greater functional impairment, worse glycemic control, poorer adherence to medication and self-care regimens, higher risk of diabetes complications, and increased risk of mortality. Short-term cognitive-behavioral therapy (CBT) has been found to be effective for treating depression in diverse patient populations, including those with co-morbid medical illness.

Objective: To examine feasibility of a group-based intervention utilizing cognitive behavioral theory-based techniques to reduce distress/depressive symptoms and improve treatment adherence (CBT-AD) in order to improve glycemic control in type 1 diabetes (T1DM).

Design: An open-phase pilot to test the feasibility of a group CBT-AD intervention for diabetes. Qualitative interviews post pilot CBT-AD group will inform the pilot RCT intervention, during which participants will be randomized to receive CBT-AD or waitlisted for group. Measures include blood draws for HbA_{1C} levels, height/weight, clinical interviews to assess depressive symptoms, and self-report assessment of diabetes self-care, and affective, cognitive, and psychosocial variables. Assessments are administered at baseline, immediately post-intervention, and 3-months after.

Setting: Clinical Research Center at the Albert Einstein College of Medicine

Participants: Adults between 18-70 with T1DM are eligible for the baseline portion of the study. Those with elevated depressive symptoms or diabetes distress are eligible for the Intervention:

Intervention: 10-week group-based cognitive behavioral therapy for medication adherence and depression (CBT-AD) Intervention:

Results & Conclusions: Completion of pilot RCT is necessary to assess the impact of CBT-AD on depression, diabetes-related distress, treatment adherence, and HbA_{1C}. Based on qualitative data from post-intervention interviews, CBT-AD for T1DM was well received by participants, who offered that the group positively impacted their mood and diabetes self-care, and that the peer support component of the group was highly beneficial. Recruiting participants for the group was an unexpected challenge, which must be explored further if broader use of the CBT-AD intervention in T1DM is to be feasible.

Abstract 17

Integrating Psychiatric Services into an OBGYN High Risk Clinic

Ariela Fielder, M.D., Carol Lau, F.N.P., Peter Bernstein, M.D.

Contact: afrieder@montefiore.org

Context: Perinatal depression is increasingly noted to be a major health concern. It affects 8-20% of pregnant patients. Ethnic minority groups in the United States appear to be at high risk for depression whether or not they are in the prenatal or postpartum period. Prominent risk factors in minority women include low socioeconomic status, poverty and lack of social support. Many cases of depression remain unrecognized during the pregnancy. Despite multiple visits to a healthcare provider, up to 50%-80% of women with perinatal depression neither report it nor are diagnosed. Undiagnosed and untreated perinatal depression can lead to severe morbidity in the mother, child and family.

Objective: Identify the prevalence and risk factors for depression during second half of pregnancy this particular population (mostly composed of minority women). Identify whether there is a need to provide psychiatric services in our OBGYN clinic

Design: The study was conducted at the Comprehensive Family Care Center of Montefiore Medical Group. A screening questionnaire for depression was conducted during the second half of the pregnancy. Demographic data and medical history were obtained for each participant. Women that scored positive for depression were given a diagnostic psychiatric interview. Women with depression were referred to Social Worker.

Results: 124 women were interviewed. There was a 13.7% prevalence of depression during the second half of pregnancy. 65% of the women with depression were Hispanics. Women who were depressed were more prone to have current stressors (76%), being unemployed (76%), had a history of depression (53%), were having an unplanned pregnancy (64%) and a minority of these women lived with the father of the baby (23.5%).

Conclusions: Depression during pregnancy is prevalent in our population mostly integrated by a minority population with significant risk factors for depression. Therefore, it is essential to provide psychiatric services in our OBGYN clinic.

Abstract 18

Singing the Blues: Screening for Depression during Pregnancy and Postpartum

Barbara Hackley, M.S., R.N., C.N.M., Chanchal Sharma Psy.D., M.S. Ed., M.A., Shira Sifton L.C.S.W., M.A., David Herzenson, M.D., Anita Hadpawat, M.D., Scm.

Contact: bhackley@montefiore.org

Background: Depression is more common than many other conditions in pregnancy. Prevalence rates for preeclampsia have been reported to be 3% and 4%- 8% for gestational diabetes compared to 15% for depression. Yet depression is overlooked in many pregnant women, often because many health care providers feel unprepared to detect or manage mental health (MH) conditions. Further compounding this problem is a paucity of available resources. Wait times for psychiatric referrals in inner city communities can be 3 months or longer.

Methods: A coordinated system of care was developed by a team of MH specialists and primary care providers at a community health center to address the unmet MH needs of pregnant and postpartum women in the South Bronx. This included implementing a screening and referral process using standardized screening tools and follow up procedures, incorporating a “meet and greet” strategy during intake into MH care and co-location of MH and primary care services. These strategies were designed to reduce stigma, improve access, and to expand providers’ skills in managing depression.

Results: In the first 6 months, 89.5% of pregnant women enrolled in care were screened for depression; of these, 31.7% screened positive for depressive symptoms and needed more in-depth evaluation. Twenty-six percent were referred to a MH specialist; 100% of these women received care. Only 13.7% of women returning for their six-week postpartum exam screened positive.

Conclusion: Using a coordinated system of care increases screening and facilitates entry to MH care.

Reproductive Health

Abstract 19**Acceptability of Home Use of Mifepristone for Medical Abortion**

Finn Schubert, B.A., Marji Gold, M.D., Cara Herbitter, M.P.H., Yael Swica, M.D., M.P.H.

Contact: fschubert@montefiore.org

Context: Women have been receiving medication abortions at Montefiore community health centers for many years. Although there is no medical indication to take mifepristone in a clinical facility, the FDA requires mifepristone to be administered in the clinic and women are given misoprostol to use at home. Previous studies suggest that most women would prefer to take both medications at home.

Objectives: This study assesses the acceptability of home-use of mifepristone for abortion to both women who chose home-use and their providers.

Methods: This multi-center study prospectively tested home use among 300 U.S. women with gestations up to 63 days who presented to one of four clinics for abortion, including 56 at the Montefiore Family Health Center. Women chose whether to take mifepristone in the clinic or at home. Data on safety, efficacy, and acceptability were collected via questionnaires and home study cards.

Results: At the Montefiore FHC, half (n=28) of the women chose home use of mifepristone. Of women for whom follow-up data was available, success rates for home users (n=23) and clinic users (n=17) of mifepristone were 95.7% and 100%, respectively. The most common reason women gave (46.4%) for choosing home use was that it offered more flexibility in their schedules. 100% of home users (n=23) said they would recommend home use to a friend.

Conclusions: Our results confirm the safety, efficacy and desirability of home-use of mifepristone. Women should be offered this choice to allow more flexibility, comfort, and privacy in their abortion experiences.

Abstract 20

Enabling women access to long acting reversible contraception (LARC)

Linda Prine, M.D., Erica Allen, M.D.

Contact: lindaprine@mac.com

Background: Our reproductive health program received two grants enabling women access to long acting reversible contraception or LARC (e.g. IUD & Implanon):

- One grant for uninsured women (Feb 2009). Educated faculty and residents on evidence for LARC insertion per grant. *Funded by Reproductive Health Education in Family Medicine*
- Another grant for teens attending NYC public high schools with school-based health clinics (Oct 2009). *Funded by NYC DOH*

Methods: Using data gathered from our electronic health record, we analyzed IUD device insertions before, during and after the start of our two grant programs. Data was gathered in 4 month increments.

A scheduling intervention occurred in Nov 2010 to promote more resident insertion of LARC devices due to grant guidelines. We tracked the numbers of LARC devices before and after the intervention to assess its effectiveness

Results:

- LARC utilization increased in our urban family medicine clinics after barriers regarding patient insurance eligibility & provider awareness of appropriate IUD candidates were overcome.
- To our Initial surprise, paid IUDs increased to a much larger degree than grant funded IUDs.
- The scheduling intervention to assign residents to procedure sessions for LARC training was very successful. Following the intervention, the number of IUDs placed by residents surpassed that of faculty and fellows.

Implications for the future: The number of patients served by community health centers is expected to double over the next five years. Family physicians will play an even more important role in contraceptive management & family planning. Our contraceptive skills will necessarily include offering long-acting reversible contraception (IUDs and Implanons) as highly effective contraception. Increased interest and availability of LARC options supports the need for increased resident training in the insertion procedures.

Abstract 21

Urban primary care providers reports of their counseling and/or provision of long-acting reversible contraception for adolescents

Susan Rubin, M.D., M.P.H., M. Diane Mckee, M.D., M.S.

Contact: surubin@montefiore.org

Objectives: Poor contraception adherence contributes to the U.S. adolescent pregnancy rate. User-independent contraceptive methods (intrauterine and implantable contraception, collectively known as long-acting reversible contraception or LARC) are used more consistently and thus could decrease unintended pregnancy. However few adolescents use LARC. This study explored primary care providers (PCPs) clinical practice with counseling about and inserting LARC for adolescents.

Methods: Qualitative semi-structured phone interviews with a purposeful random sampling of PCPs (family physicians, pediatricians and obstetrician/gynecologists) who care for adolescents at outpatient urban hospital-owned facilities. Interview guide explored barriers and facilitators influencing inclusion of LARC options during contraception counseling and provision. Analysis with standard qualitative methods.

Results: Conducted 25 interviews (6 family physicians, 10 pediatricians and 9 obstetrician/gynecologists). Only two family medicine sites had implantable contraception, no other sites had the methods and few were counseling about this option due to limited knowledge and access. Pediatricians described limited comfort with contraception prescription and never discuss IUC. Other PCPs had varying levels of comfort with IUC for adolescents. Many PCPs who counsel and/or insert IUC for adolescents do so with some of concern about increasing STI risk; they cite importance of clinical guidelines. Cost of the device itself is the number one barrier identified by those PCPs who insert IUC.

Conclusions: PCPs have great variability in their counseling and provision of IUC for adolescents. There is virtually no access to implantable contraception. Interventions to increase LARC access for adolescents in primary care must be tailored to the PCP's scope of practice and their clinical environment.

Screening and Prevention

Abstract 22

Are Necessary Elements for Provision of Sexual Health Services Available to Urban Adolescents at Every Visit? : A Survey of Adolescents and Parents

M. Diane McKee, M.D., Elizabeth Alderman, M.D., Jason Fletcher, Ph.D., Susan E. Rubin, M.D., M.P.H., Lucia O'Sullivan, Ph.D., Giselle Campos, B.S.

Contact: diane.mckee@einstein.yu.edu

Purpose: In preparation for a practice-based intervention to improve delivery of sexual health services and rates of screening for Sexually Transmitted Infections (STIs), we obtained parent and adolescent reports of visits (content of visits and perceptions of interactions with clinicians) and rates of screening for STIs among at-risk youth.

Methods: Youth (12-19 years) and parents (if accompanied) presenting for care at 4 urban health centers were invited to complete post-visit surveys during a visit with a primary care clinician (PCP). STI screening results were obtained from the hospital clinical information system for all youth seen and linked to survey responses for the surveyed subsample.

Results: Surveyed youth (n=101) had a mean age of 16.1 years, were 66% female, 62% Hispanic, and 46% sexually active. Youth reported time alone with the PCP in 60% of accompanied visits (range 38-71% across sites). Time alone varied by age (0% for 12 and 13 year olds, 60% 14-15, 74% >16) but not gender. It occurred significantly more frequently in 71% of preventive visits versus 33% of non-preventive visits ($p = .006$). Youth reported being asked about sexual activity in 63% of visits (72% males and 60% females) and about sexual orientation in 18%.

Parents and youth reported high levels of satisfaction with visits (81% and 59%, respectively). Only 33% of youth reported complete trust that doctors would keep information private. Among adolescents, discomfort was more common for females (40%) compared to males (10%).

Of all youth seen during the sampling period, 3.1% of males and 11.4% of females had an HIV test; 3.6% of males and 17.5% of females were tested for Gonorrhea/Chlamydia (GC). Screening rates for sexually active surveyed youth were as follows: for HIV, 0 males and 17.9% of females; for GC, 0 males and 32% of females.

Conclusions: Time alone occurs infrequently in non-preventive visits and with younger adolescents. Adolescents and parents report high comfort with clinicians, though youth are more skeptical than parents and have specific issues with trust related to confidentiality. Clinicians in this setting rarely screen asymptomatic males for STIs, and are not screening females consistently enough.

Abstract 23

Know Your HIV Status: Decrease Transmission, Increase Health

Amy Myslik, M.A., Rebecca DiLuzio, L.M.S.W.

Contact: amyslik@institute2000.org

Objective: The Expanded HIV Testing Program objective at the Institute for Family Health (IFH) was derived from recent changes to New York State HIV testing laws. IFH has adopted HIV screening as a standard of medical care to all patients 13 and older in order to increase the HIV tests done in the agency.

Design: The design of the project has ensured an integrated testing system that has been implemented in all IFH medical centers. The project leaders train medical staff to incorporate HIV tests into the patient workflow and to approach any barriers that may arise. The outcomes are measured by the project leaders utilizing a data reporting system to access the HIV tests offered refused and accepted. These numbers are compared monthly and project leaders then create plans to improve outcomes.

Setting: The Expanded HIV Testing Program is being implemented in all upstate and downstate medical centers at IFH. This includes but is not limited to the family practice, dental, and gynecology departments.

Participants: Participants of this project are established patients at IFH, the HIV Workgroup and the HIV QI Team, and project leaders. In addition, nurse managers, medical directors and practice administrators are members of the project team.

Instrument & Intervention: The electronic medical record is designed to remind staff once or twice a year, depending on risk factors, to recommend testing. Patients' declination or acceptance is documented in their medical records as well as pre and post test counseling notes. For positive test results a plan is in place to offer patients partner notification services, medical, case management and psychosocial services within IFH offices. Project team leaders review workflow and testing documentation with medical staff to ensure proper patient care and notation of services given.

Results & Conclusions: Results have demonstrated an increase in test offered and accepted by patients since the project was implemented.

Abstract 24

A Collaborative Approach to Control Hypertension in Diabetes (COACH)

M. Diane McKee, M.D., Jason Fletcher, Ph.D., Irina Segal, R.N., C.D.E., Stacia Maher, Ed.D., M.P.H., Alexander Ramirez, B.A.

Contact: diane.mckee@einstein.yu.edu

Objective: To develop and pilot an intervention to improve blood pressure (BP) and other intermediate outcomes (A1c, LDL) of diabetes in a low-income ethnically diverse population.

Research Design & Methods: English- or Spanish-speaking primary care patients with BP > 140/90 and any level of A1c were randomized to usual care (n=24) or intervention (n=31). Home health nurses assessed self-management, medication adherence, and performed health behavior counseling. Home telemetry units transmitted daily BP and glucose results to primary care providers [PCP] to facilitate intensified treatment.

Results: After controlling for baseline levels, a significantly larger proportion of the intervention group was at goal for BP (adjusted OR = 9.3, p = .006), and A1c (AOR = 4.3, p = .049), but not for LDL (AOR = 1.1, p = .86).

Conclusions: The combination of enhanced feedback to patients and their PCPs and behavior change support is effective for improving BP, and may also promote glucose improvements.

Abstract 25

Mental Health and Cancer (MHC) Connection: A CBPR Partnership to Improve Access to Mental Health Care and Promote Timely, Age-Appropriate Cancer Screening

Elisa Weiss, Ph.D., Abigail Williams, M.P.H., Jennifer Erb-Downward, M.P.H., Emilie Bruzelius, B.A., Nicole Maysonet, B.A., David W. Lounsbury, Ph.D.

Contact: elisa.weiss@einstein.yu.edu

A growing body of literature suggests that unmet mental health needs are associated with less participation in cancer screening and other preventive health behaviors. Conversely, the management of mental illness through regular utilization of care appears to increase the likelihood of obtaining cancer screening and participating in other preventive care. Our project, “MHC Connection,” emanated from conversations with community-based organizations about cancer screening in the Bronx, NY, in which they indicated that their inability to connect clients to sufficient mental health services was a more immediate concern than cancer screening. In response to this feedback, MHC Connection takes a community-based participatory research approach to identify feasible strategies for improving access to mental health care, and in turn, promote more utilization of timely, age-appropriate cancer screening services. A Working Group of six community-based organizations and Einstein staff was created in early 2010. This group developed a qualitative interview guide for Bronx medical and social service providers, who were recommended by the Working Group members and identified via snowball sampling. Interviews were transcribed and open coded by two staff separately using NVIVO software. Thirty-seven interviews have been completed. All respondents worked in the Bronx, and most had lived there at some point. Initial analysis described the role that positive and negative community-level factors play in shaping mental health, and underscored how untreated mental health issues have multiplicative repercussions on the lives of Bronx residents, including their ability to receive preventive care. Respondents suggested a definition of mental health that includes the impact of daily life stressors and environmental-level factors particular to a resource-poor, urban Context: This picture of mental health will lay the foundation for developing a collaborative grant to fund an intervention through the existing MHC Connection partnership.

Abstract 26

Bottle-Weaning Interventions: A "Back Channel" Approach to Preventing Obesity and Iron Deficiency Anemia

Richard Kahn, M.S., Ph.D. (candidate), Karen Bonuck, Ph.D., Christel Hyden, M.S., Ph.D. (candidate)
Contact: richard.kahn2@verizon.net

Overview: As part of a RCT of a WIC-based intervention to promote timely weaning from the bottle, we implemented a 24 hour recall with parents of 12 month olds recruited to our study. As background, prolonged/excess bottle use is associated with overweight, dental caries, and iron deficiency anemia.

Design: We enrolled n=300 12-month olds from two Bronx WIC sites who were drinking ≥ 2 non-water bottles/day, and conducted follow-up interviews at 15, 18, and 24 months to ascertain: bottle use, dietary intake, and mealtime behaviors. Prior to WIC nutritionists delivering the intervention, study staff conducted 24 hour dietary recalls of the child's intake the prior day, using the computerized Nutrition Data Systems for Research (NDSR) program. Parents were taught by study staff how to use measuring cups, bowls, and spoons to estimate portion size.

Main findings: Our computerized 24 hour dietary recalls appear to have functioned as an intervention. The recalls increased parents' awareness of childrens' total intake, and provided parents with new skills/knowledge in portion sizes. Parents found the 24 hour recall easy, and liked doing it: "*I found it really easy,*" and would recommend it to others, "*It's really cool. I think a lot of parents would like to see how much they are eating.*" Parents became more aware of their child's diet: "*You don't realize how much you're giving him to eat, until you measure it,*" and seemed motivated to make changes based on that knowledge, "*And when she read it back to me I started thinking about less snacks and more healthy food.*"

Conclusion: As with diet diaries with adults, detailed diet recalls may motivate parents to make changes in the types and amounts of food they serve to their child.

Abstract 27

Dynamics Modeling as a Tool for Disseminating the Public Health Service Tobacco Treatment Guideline

David W. Lounsbury, Ph.D., Jamie Ostroff, Ph.D., Barbara Hart, M.P.A., Lisa Marini, A.B., Hal Strelnick, M.D.

Contact: david.lounsbury@einstein.yu.edu

In collaboration with the New York State Tobacco Control Program and the National Institute of Drug Abuse (1R03DA022278-01; Lounsbury, PI), we examined the utility of system dynamics modeling as a means to develop a simulation tool to foster understanding about how to improve implementation of the PHS Guideline for Treating Tobacco Use and Dependence in primary care practices. System dynamics models have been developed to study community and population impacts of varied public health problems and policies, including tobacco policies. However, these works have not modeled the dynamics of individual practice settings, nor have they used system dynamics models to directly educate and influence physician practices. Specifically, we examined the dynamics of tobacco treatment in small primary care practices (1-5 physicians per practice) in Queens, NY. To determine the feasibility and acceptability of using the simulation tool, we analyzed discourse from each practice's academic detailing sessions as well as structured assessments of provider behaviors (i.e., chart review and provider self-reported practices). Results indicate that providers found tailored simulation output to be a greater source of motivation to enhance treatment for patients who use tobacco than feedback about their self-reported practices or independent chart reviews. We concluded that system dynamics models are effective tools for communicating complexity to busy health care providers. However, our study design was not able to detect more than an effect on behavioral intent to change. Additional research is needed to assess how tools such as system dynamics models can promote sustainable practice change. Key questions regarding how to apply our model in the future include: How much complexity is sufficient to motivate practice change? And, given time and effort required to facilitate office visits, what alternative ways could be used to expose providers to the model (e.g., web-based platforms with structured, interactive user interface)?

Abstract 28

A Participatory Health Education and Empowerment Intervention to Address Cancer and Obesity in South Asian and Latino Immigrant Women

Viraj Patel, M.D., M. Diane McKee, M.D., M.S., Alison Karasz, Ph.D.

Contact: vpatel@montefiore.org

Background: Latino and South Asian immigrants face a heavy disease burden associated with obesity (e.g. diabetes, hypertension, and hyperlipidemia) and have low rates of cancer screening. Among both groups, health risks relate to a variety of socio-economic, cultural, linguistic and other structural barriers. Culturally sensitive, cost effective and sustainable interventions that can be implemented in these vulnerable, fast growing immigrant communities are urgently needed.

Objectives:

- 1) To develop a women's health intervention, based on situated learning theory and CBPR principles, to address cancer and obesity prevention among Latino and South Asian primary care patients.
- 2) To implement the intervention in four primary care practice sites.
- 3) To evaluate the implementation, acceptability and feasibility of the intervention, and obtain preliminary estimates of effectiveness.

Setting: Health Education Action for Lifestyle change (HEAL) will be a primary care based intervention designed to address health prevention among women in immigrant communities in New York City. HEAL will address health prevention in two core areas: cancer and obesity, among Latino and South Asian primary care patients. Projects will be located in primary care sites affiliated with the Department of Family Medicine's NYC RING research network, and with our new primary care research network, SAPPHIRE (South Asian Practice Partnership for Health Improvement and Research).

Project design: Community Health Workers (CHW) will be recruited from practice sites and given extensive training. CHWs will then recruit other patients from practices to form participatory action groups. These groups will explore women's health and health risks, assess their own health risks, establish common health prevention goals, and design and implement strategies for health prevention. After implementing interventions among themselves, action groups will engage in community outreach. They will design outreach activities and implement them in NYC RING and SAPPHIRE primary care network sites. The proposed pilot project if successful will serve as a model for a larger intervention to be implemented in NYC RING and SAPPHIRE practices.



Abstract 29

Compliance of Family Medicine Residents in Administering Gardasil Vaccine

Andrea Maritato, M.D., Alana Orkin, M.D., Diana Mateus, D.O., Natacha Tamdji, D.O.

Contact: ntamdji@jhmc.org

Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States, infecting approximately 6.2 million persons each year. Although most infections are self-limited and cause no clinical symptoms, persistent infection with oncogenic types of HPV can cause cervical cancer in women. HPV infection also causes genital warts and is associated with other anogenital cancers in men and women.

In June 2006, the U.S. Food and Drug Administration approved the quadrivalent HPV vaccine (Gardasil) for use in females nine to twenty-six years of age. The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention recently issued guidelines recommending that females receive three doses of the vaccine at 0, 2 and 6 months from initiation; ideally at 11 or 12 years of age. The vaccine prevents over 95 percent of HPV infections caused by serotypes 6, 11, 16, and 18, thus blocking the initial pathogenic step that leads to 70 percent of cervical cancers*.

The study consisted of a chart review of female patients 9-26 yrs of age who have frequented the Family Medicine Center from June 2008 to Jan 2010 and have been offered and/or completed the Gardasil vaccination series. We obtained this information to highlight the areas in which we as residents are/are not compliant with the recommendations. A resident survey was conducted to obtain resident perceptions regarding personal knowledge base and practices. Our goal was to enhance our performance in the clinic setting as this is an area that provides an opportunity for important anticipatory guidance during early adolescence.

*Armstrong, Carrie. *Practice Guidelines. ACIP Releases Recommendations on Quadrivalent Human Papillomavirus Vaccine*. AAFP. 2007.

Abstract 30

Increased Hepatitis C (HCV) Testing Observed During Community-Based Interventions

Southern WN, Smith BD, Drainoni M, Christiansen CL, McKee MD, Gifford AL, Weinbaum CM, Thompson D, Koppelman E, Maher S, Litwin AH

Contact: wsouther@montefiore.org, alitwin@montefiore.org

Purpose: To evaluate two interventions designed to increase Hepatitis C (HCV) testing in the ambulatory care practices of a large urban teaching hospital.

Research objective: The majority of the estimated 3.2 million chronically HCV infected persons in the U.S are unaware of their status, even though effective treatment is available. Although testing for patients at risk is recommended, many patients at risk remain untested. Our objective was to evaluate both an intervention to increase HCV testing in at-risk patients by examining specific risk factors, and a second intervention to promote testing in all patients born within a high-prevalence birth cohort (1945-1964).

Study design: Prospective serial cross-sectional study of community-based interventions.

Population studied: The study subjects were previously untested patients with a primary care visit to Montefiore Medical Center clinics during one of three phases of the study: 1) Baseline Phase, 2) Enhanced Screener Phase where stickers placed in charts prompted providers to order HCV tests based on presence of risk factors and 3) Birth-Cohort Phase where stickers prompted providers to order HCV tests on patients born in the high-prevalence birth cohort.

Principal findings: 6,591 subjects in the baseline phase, 8,981 subjects in the enhanced screener phase, and 10,165 subjects in the birth-cohort phase were examined. Both interventions were correlated with an increased proportion of subjects tested for HCV from 6.0% at baseline to 13.1% in the enhanced screener phase ($p < 0.001$) and 9.9% in the birth-cohort phase ($p < 0.001$). HCV testing in high-risk patients increased from 5.0% at baseline to 12.7% in the enhanced screener phase ($p < 0.001$) and 7.8% in the birth cohort phase ($P < 0.001$). There were 32 new HCV diagnoses at baseline (0.5% of all subjects) versus 62 new diagnoses in the enhanced screener phase (0.7%) and 59 new diagnoses in the birth cohort phase (0.6%).

Conclusions: We found that both interventions significantly increased testing in patients at risk.

Implications for policy: Either approach could be widely adopted in primary care settings to increase identification of HCV-infected patients nationwide as newer effective antiviral treatment will be available soon. Such approaches could also be integrated within the electronic medical record, and further studies should examine alternative approaches to further increase testing and identification of HCV-infected patients.

Abstract 31**Maternal Perceptions of Weight and Obesity in an Urban Population**

Shilpi Mehta, M.D., Jennifer Lischewski Goel, M.P.H., Karen Bonuck, Ph.D., Linzhi Xu, Ph.D., Mindy Brittner, Peter S. Bernstein, M.D., M.P.H.

Contact: jennifer.lischewski@einstein.yu.edu

Objective: Pre-pregnancy obesity and gestational weight gain are linked to adverse neonatal and obstetric outcomes. As pre-pregnancy weight is a significant modifier of weight gain in pregnancy, we sought to determine whether prenatal patients at 2 Bronx health clinics accurately perceived their overweight status.

Study design: Data are from participants in 2 randomized, controlled trials of prenatal-care based breastfeeding promotion interventions. 941 women with 12-26 week, singleton pregnancies, were enrolled from 2008-2010. In face-to-face enrollment interviews, subjects reported if they had any of a list of health conditions, including overweight/obesity. Those with pre-pregnancy self-reported weight and height available were included. The WHO Body Mass Index (BMI) was used to assign overweight or obese status. Chi-squared analysis was done to compare perceived overweight/obesity status to calculated BMI, and demographics of overweight/obese women (BMI >25) grouped by perception of weight status.

Results: 734 participants met inclusion criteria; 64% (n=473) were obese (BMI>30); 20% (n= 96) identified as such. Of the 19% (n=143) of women who were overweight (BMI 25-30), 2.1% (n=3) reported they were overweight. 16% (n=118) of women were normal or underweight; none misperceived their weight. US-born women were more likely to correctly assess weight status; other demographics did not differ between women with a BMI >25 based on perception of weight (Table). Diabetic women were more likely to accurately assess their overweight/obese status (31% v. 15%; p=0.0015).

Conclusion: In a large, urban prenatal population, 84% of women were overweight/obese, yet only 16% perceived themselves to be so. This weight-perception disparity is more pronounced in foreign-born women. As expected, diabetic women, likely educated about obesity, more accurately assessed their overweight/obesity status. Accurate perception of weight status is the basis for lifestyle change. To improve both maternal and fetal health outcomes among overweight women, practitioners must understand a patient's perception of her own weight.



Abstract 32

HPTN 065 (TLC-Plus): A Study to Evaluate the Feasibility of a Community-Focused Approach for HIV Prevention in the United States

Barry Zingman, M.D., Paul Meissner, MSPH

Contact: pmeissne@montefiore.org

Context: TLC-Plus is being conducted by a collaborative team of researchers associated with the HIV Prevention Trials Network (HPTN), the U.S. Centers for Disease Control and Prevention (CDC), the Departments of Health in the intervention and non-intervention communities, clinicians and other key personnel at HIV test and care sites, and community members. The study is being funded by the National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health (NIH). NIAID funds the HPTN.

The test, link-to-care plus treatment model of HIV prevention is based on two principles:

1. Most people who know they are infected with HIV modify their behavior to prevent transmitting the virus to others.
2. When linked to medical care and given appropriate treatment, including antiretroviral medications according to current U.S. guidelines, individuals with HIV can live longer, healthier lives. In addition, antiretroviral medications can significantly reduce the amount of HIV in an infected individual (known as viral load), potentially reducing his or her risk of transmitting the virus to others.

Objective: This is a three year research study to evaluate the feasibility of a community-focused strategy to expand HIV testing, diagnose HIV infection early, link HIV-positive individuals to medical care, initiate treatment according to current guidelines, and ensure that patients adhere to their treatment regimens.

Study design: TLC-Plus consists of five interrelated study components: Expanded HIV Testing: Linkage-to-Care, Viral Suppression, Prevention for Positives, Patient and Provider Surveys.

Setting: Bronx, New York, and Washington, D.C. 20 sites in the Bronx

Results: TLC-Plus is not designed to measure changes in the number of new cases of HIV infection in the communities where the study will take place. Study's results will provide key information for the design of future research and potentially for the implementation of the test, link-to-care plus treatment model of HIV prevention in the United States.

Health Systems

Abstract 33

An approach to evaluating transformation to Patient-Centered Medical Home

Claudia Lechuga, M.S., Paul Meissner, M.S.P.H., Arthur E. Blank, Ph.D., David W. Lounsbury, Ph.D., M. Diane McKee, M.D., M.S.

Contact: claudia.lechuga@einstein.yu.edu

The New York City Research and Improvement Networking Group (NYC RING), a PBRN focusing on the urban underserved population in the Bronx, NY, will describe an evaluation framework for the Patient Centered Medical Home (PCMH). The objectives of the evaluation are to provide critical data to policymakers and administrators on how to invest resources for maximal effect and to guide the extension of the model beyond two pilot sites within a large integrated care-delivery system, to a broad array of primary care settings

The evaluation will be conducted by a multidisciplinary team integrated with existing implementation efforts, but able to maintain a sufficiently detached position to achieve arm's length objectivity. The evaluation will use a mixed-methods approach and be informed by Normalization Process Theory, a sociological theory of change focused on understanding the actions of participants involved, and how those changes become embedded or normalized over time. Our evaluation approach involves 1) identifying and tracking new care processes launched by PCMH pilot clinics and assessing the extent to which these efforts are implemented and sustained; 2) establishing the measurement strategy and data flow, and conducting analyses for main outcomes of quality of preventive and chronic disease care, patient centeredness, and staff satisfaction; 3) integrating qualitative and quantitative data to explain why some new care processes were effectively implemented and sustained while others were not; and 4) convening an independent external advisory board to advise and review evaluation findings.

Conducting this evaluation in an urban primary care setting can also help establish a framework towards future evaluations addressing the effect of the PCMH on decreasing disparities among different patient subgroups.

Abstract 34

Implementing Group Well Child Visits as Part of a Patient Centered Medical Home at a Federally Qualified Health Center

Alice Teich, M.D., Rebecca Williams, M.D., M.P.H.E., Elizabeth Alt, M.D., M.P.H., Carol Mendez, M.D., Margaret Rosenberg, M.D.

Contact: ateich@montefiore.org

Context: Studies suggest that group visits with patients in certain chronic disease management and prenatal care groups can improve overall health and well being, compared to individual visits. In addition to potential traditionally measured health benefits, these group visits may improve patient and community engagement, and encourage patient and family involvement and shared decision-making. To further assess the potential of group visits in comparison to individual visits, the Department of Family and Social Medicine of Montefiore Medical Center is implementing Centering Parenting (CP), a group-visit approach to the well-child visit, at a Federally Qualified Health Center in an urban primary care setting designated as Patient-Centered Medical Home.

Study participants will be parent-baby diads and established patients at the Family Health Center (FHC). Parent-baby groups consisting of 5-10 pairs (10-20 patients) will meet at predefined routine well-child check-up/vaccine visits with physician/co-investigators. Nursing and other clinic-staff will also assist and participate in the groups.

Our study aims are to evaluate the effectiveness of group visits compared to individual provider visits for routine well childcare.

Furthermore this intervention can provide more quality time for patients with physicians (and vice-versa) and provide time and space for patients to interact meaningfully with each other (parents and babies in similar life circumstances, given age of children and location of health care delivery).

Objectives: Overall objectives of this study are to evaluate the effectiveness of group visits versus individual provider visits for routine well childcare.

Long-term objectives and goals of this approach to care include:

- Develop parenting skills
- Promote self care and infant care skills
- Reduce abuse, neglect, injuries and hospitalizations
- Promote healthy growth and development (ie., immunizations, regular health supervision, developmental assessments)
- Promote healthy family interactions and development
- Reduce unintended pregnancies
- Promote the use of community resources

Abstract 35

Using a Computer Adaptive Test to Identify Depressive Disorders in Primary Care

Matthew Wingo, Arthur E. Blank, PhD, Diane McKee MD MS, Matthias Rose, MD PhD, Janine Devine PhD Dipl.-Psych, Giselle Campos, Kelsey Hoidal, Nally Calzado, Claudia Lechuga MS

Contact: Giselle.campos@einstein.yu.edu

Mental disorders are among the most prevalent conditions in the United States, and their burden for the individual and society is tremendous. Nevertheless, they are still widely under-diagnosed in community-based health care systems. One way to help primary care physicians identify and monitor mental health problems is to use self-administered patient questionnaires. There are a number of well-developed instruments available, but integration into clinical practice has rarely been achieved. Although psychometric characteristics of many tools are good, they still do not meet clinical needs, and a common metric to compare results from different tools is still missing. In addition, paper-pencil questionnaires have to be scored manually, which impose a key barrier for clinical practice, as provider reports for high-risk patients must be timely and selective to be effective.

Responding to those problems Matthias et al recently built a Computer Adaptive Test based on the Item Response Theory to assess the mental health status of patients in community based health care settings (MH-CAT). Reports can be printed instantly showing severity of depressive symptoms, self reported treatment and adherence.

With this study, we aim demonstrate its feasibility as a routine screening instrument in clinical practice, and assess its impact for case recognition and clinical decision-making. We will introduce the MH-CAT assessment to into Williamsbridge Family Practice and East Tremont Health Center, two large health centers of the New York City Research and Improvement Networking Group, located in underserved communities in the Bronx will introduce the MH-CAT into their routine care. Within a cross-over observational study we will evaluate the screening success and impact on clinical decision making in comparison with the PHQ-9. Approximately 2,750 patients will be screened using the MH-CAT. Positive screened patients will be assessed with the Structured Clinical Interview for DSM-IV Axis I Disorders to confirm the diagnostic classification and followed-up for three month to assess which actions have been taken.

Abstract 36

Staff perceptions of Patient Centered Medical Home implementation in two urban clinics

Scott Ikeda, M.D., M.P.H., Feyisara Akanki, M.D., Claudia Lechuga, M.S., Eliana Korin, Psy.D., M. Diane McKee, M.D., M.S.

Contact: siked@alum.mit.edu

Context: A large body of literature continues to grow on the myriad problems facing the US primary care system. The Patient Centered Medical Home (PCMH), has received renewed interest as a way to improve the quality of primary care while containing costs. As a practice transforms into a PCMH, its staff must be involved in carrying out change, however staff perceptions of the PCMH, their roles in the change process, and the practice's capacity for change may not be congruent.

Objective: To compare staff opinions of the clinic environment, the PCMH concept, and the PCMH change process at two primary care clinics in the Bronx, NY.

Design: A qualitative study describing the results of focus groups from two clinics undergoing PCMH implementation.

Setting: The clinics are located in densely populated areas (Bronx, NY) during a time when the parent organization has begun to implement PCMH principles in its primary care sites.

Main outcome measure: To describe and compare staff opinions and beliefs regarding the PCMH transformation process.

Participants: Participants are clinicians including physicians, nurses, and PCTs; and support staff including administrative and clerical workers at the two clinics.

Methodology: Staff were randomly selected to form two focus groups at each site. One facilitator and one note-taker will conduct the group discussions, which will be audio recorded, then transcribed and analyzed for themes.

Results & Conclusions: We anticipate themes will emerge regarding specific areas needing improvement in each clinic, how different levels of staff perceive the PCMH, and each clinic's capacity to implement the PCMH. We further anticipate comparison of these themes amongst the different levels of staff and between the two clinics will yield insight into how staff perceptions can inform the PCMH transformation process in a way useful to other practices as they begin their own transformations.

Abstract 37

HIT Innovations to Improve Diabetes Care in a Community Health Center Setting

Elizabeth Molina-Ortiz, M.D., M.P.H., Alexandra Salazar, M.S., R.D., C.D.E.

Contact: asalazar@institute2000.org

Objective: As a community health center, the Institute for Family Health is at the frontlines of the diabetes epidemic. In response, the Institute initiated multiple health information technology (HIT) innovations to improve the health of patients living with diabetes and to eliminate racial and ethnic diabetes disparities.

Methods: Using its electronic health record (EHR) system, the Institute created population and patient level innovations to improve the health of patients living with diabetes. First, the Institute developed a registry to identify those most at risk and in need of interventions. Further, the Institute established *IFH Stats*, a monthly quality care report to enable tracking and analysis of improvements in clinical measures (both for individual patients and in aggregate). The Institute also implemented clinical decision support tools, including best practice alerts and *SmartSets* to optimize office visits with evidence-based tools.

Results: These innovations effectively leverage HIT to identify and address disparities in diabetes control. In recognition of the Institute's high quality of care for patients with diabetes, NCQA has acknowledged six of the Institute's health centers through its Diabetes Recognition Program. The Institute expects its other health centers will also receive this recognition within two years.

Conclusion: The Institute recognizes that in a large health delivery system, EHR data can facilitate a population-based approach to disease management. Consequently, utilizing EHR's robust ability to capture and report data, in conjunction with evidence-based guidelines for diabetes care, the Institute ensures that patients at highest risk for diabetes-related complications receive appropriate and timely services.

Learning objective: After completing this presentation, attendees will be able to identify how an EHR system can be used to improve patient- and population-level diabetes care through the application of a patient registry, provider-based quality care reports, and clinical decision support tools.

Abstract 38

Bringing Baby Home (to their Medical Home) from the Hospital: Communication between Nursery and Ambulatory Care Providers

Heather O'Donnell, M.D., M.Sc., Rebecca Trachtman, B.A., Andrew Racine, M.D., Ph.D.

Contact: hodonnel@montefiore.org

Context: Transitioning across healthcare settings and providers puts patients at risk for medical errors and poor health outcomes. Although robust provider communication may reduce these risks, little is known about communication among providers caring for newborns transitioning from the inpatient to outpatient setting.

Objectives: To model current communication practices between nursery and ambulatory care providers as newborns transition home from the hospital using the Shannon Weaver model and to assess how communication elements (i.e. source, channel) impact providers' perceptions of current practices

Design: Qualitative study using semi-structured interviews with key informants (managing or experienced providers) from a diverse sample of clinics in New York City. Interview transcripts were coded independently by two investigators and the data were then grouped by communication element to establish themes and model communication practices.

Results: Interviews were completed at 15 clinics, diverse in location, ownership, electronic medical record (EMR) use, residency training and nursery rounding responsibilities. The most common communication **channel** described was a written message carried by the parent from the hospital to the clinic. If the communication **source** was a provider from a hospital associated with the clinic, back-up **channels** of communication were often available. Only clinics with a shared hospital-clinic EMR system that included electronic notes used electronic communication as their primary **channel**. Social concerns and abnormal prenatal ultrasounds were often cited as missing from the **message**. Messages were rarely directed to a specific **receiver** and receiving providers reported rarely being able to ask questions of nursery providers or being informed when newborns needing follow-up were coming to their clinic.

Conclusions: Modeling current communication practices can identify areas suitable for intervention and study as healthcare centers strive to become medical homes.

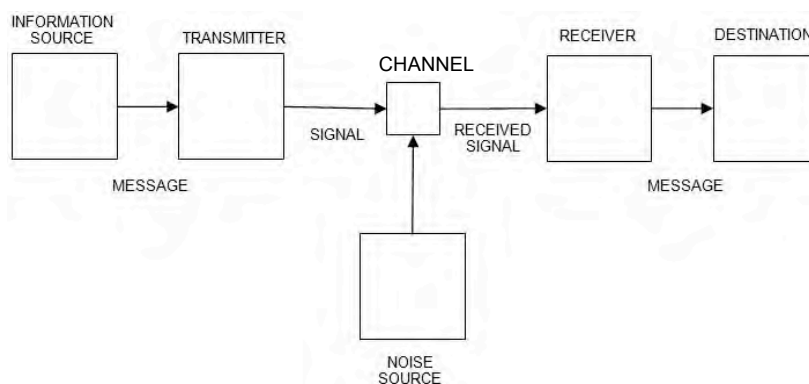


Figure: Shannon CE, Weaver W. *A Mathematical Model of Communication*. Urbana, IL: University of Illinois Press; 1949.

Abstract 39

Analysis of Emergency Department Utilization by Montefiore's Family Medicine Residency Practices

Anjani Reddy, M.D., Victoria Gorski, M.D., Bruce Soloway, M.D.

Contact: anreddy@montefiore.org

All too often, patients are utilizing emergency departments as their source for primary care. Not only does this add to the ever-increasing costs of health care, it also signals a failure of primary care to adequately address the needs of our patient population.

The aim of this quality improvement project is to better understand our patients' overuse of the ED. This was approached in two steps: (1) Clinical Looking Glass (a computer application that processes EMR information through a statistical server) was applied to review the frequency of patient visits to our urban FQHC and to the local ED. A subgroup was selected based on number of ED visits (more than 8 visits over 18 months). After reviewing this subgroup's medical diagnoses, it was found that over half of these patients have a psychiatric diagnosis. Furthermore, chart reviews of these patients have indicated that this patient population has multiple psychosocial issues that also likely contribute to their high use of the ED. With a recent transition of our clinic to a PCMH, we hope to address these patients' needs more effectively. (2) With the goal of understanding some of the key barriers to effective care, the next step is to conduct interviews of some key informants. After reviewing these interviews for underlying themes and patterns, we will hopefully be able to apply our findings to the PCMH scaffold that our clinic is adopting, and potentially create a patient-centered approach to addressing the current overuse of the ED.

Abstract 40

Bringing Baby Home (to their Medical Home) from the Hospital: Scheduling the First Outpatient Appointment

Heather O'Donnell, M.D., M.Sc., Rebecca Trachtman, B.A., Andrew Racine, M.D., Ph.D.

Contact: hodonnell@montefiore.org

Context: One of the central principles of the family-centered medical home is that care is coordinated across all domains of the healthcare system. Although the AAP recommends the first outpatient visit for most newborns occur within 2-3 days after discharge, many newborns do not receive this care within this timeframe. Certain characteristics of initial appointment scheduling in a complex healthcare system may serve as barriers to appropriate care and care coordination may be able to facilitate this process.

Objective: To describe current methods for scheduling first outpatient appointment after hospital discharge for newborns that transition to a diverse sample of pediatric and family medicine clinics in New York City and to identify barriers and potential facilitators to the scheduling process.

Design: Qualitative study using semi-structured interviews with key informants (managing or experienced providers) from fifteen practices diverse in location, ownership, electronic medical record use, residency training and nursery rounding responsibilities. Interview transcripts were coded independently by two investigators, and scheduling methods, barriers and facilitators were discussed and agreed upon by both investigators.

Results: Three main methods of scheduling the first appointment were described (1) Hospital provider/staff makes appointment before the newborn is discharged; (2) Family calls clinic for the appointment; (3) No appointment is made, family walks-in. Major barriers to scheduling included (1) No available provider appointments; (2) No (or poorly recognized) clinic policy about scheduling appointments for newborns; (3) Inability to make appointments over the weekends. In addition, in instances where families called the clinic, the families often needed to advocate to ensure their child received a timely visit. Providers described several facilitators including: (1) provider schedules with appointments saved for newborns; (2) scheduling done by providers or trained staff, especially before discharge; (3) use of computer scheduling that allowed scheduling over the weekend.

Conclusions: Current methods for scheduling initial newborn appointments are often fraught with difficulties. However several potential facilitators have been identified for future implementation and study.



Abstract 41

Bronx Ongoing Pediatric Screening (BOPS) in the Medical Home

Andrew Racine, M.D., Ph.D., M. Diane McKee, M.D., M.S., Christopher Kus, M.D., M.P.H., Rahil Briggs, Psy.D., Paul Meissner, M.S.P.H., Arthur E. Blank, Ph.D., Michele Lloyd-Puryear, M.D., Ph.D., Deborah V. York, M.P.H., Kelsey Hoidal, B.S.

Contact: deborah.york@einstein.yu.edu

The Division of General Pediatrics of the Albert Einstein College of Medicine, the New York City Research and Improvement Networking Group (NYC RING), the Division of Family Health of the New York State Department of Health, and Chapter 3 District II of the American Academy of Pediatrics will collaborate to develop, implement and evaluate **Bronx Ongoing Pediatric Screening (BOPS)** in the Medical Home. Within the context of a primary care practice network in Bronx, New York, the poorest urban county in the United States, the objective of BOPS is to incorporate continuous, comprehensive, coordinated, evidence-based, culturally appropriate screening strategies across the lifespan from birth through adolescence. During the four-year project, we will emphasize four elements posing particular difficulties for pediatric practitioners: 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.

To achieve the goal of establishing a robust screening regimen across these four domains, we will combine in a novel arrangement, two distinct well-validated approaches to inducing operational change in primary care practices: a) a modified **learning collaborative** fashioned after the Institute for Health Improvement's Breakthrough Series, and b) a **pay-for-quality** monetary incentive for participating practices that will serve two purposes – to provide immediate material incentives linked to goal achievement, and to prefigure eventual reimbursement advantages envisioned by New York State for practices that achieve certain characteristics of the medical home.

Abstract 42

Hospital Discharge Follow-up Program

Kathleen Byrne, R.N., M.P.H., Anne Meara, R.N., M.B.A., Sandra Mitchell, B.S.N., Francine Williams, M.S., Lisa Bollotino

Contact: kbyrne@montefiore.org

Background: Reducing rates of re-hospitalization has been a focus of hospital systems as a way to improve quality of care and reduce costs. Currently national data shows that almost 20% of Medicare enrollees are readmitted within 30 days of discharge.

Method: CMO implemented a Hospital Discharge Follow-up Program in May 2009. Using a series of standardized questions linked to interventions, RN staff made calls within 72 hours of hospital discharge to patients at high risk for readmission.

Results: Between implementation of the CMO Hospital Discharge Follow-up Program in May 2009 and year end 2010, hospital discharge follow-up phone calls were placed to 3,445 patients. In the 2,187 patients reached and assessed, the 30 day readmission rate was 14.1% compared to 21.5% for the 1,258 patients not reached and assessed. As compared to an historical cohort of 2,809 hospitalized in 2008 and meeting program criteria, there was a 33% decrease in readmissions.

Conclusion: Using this observational approach, CMO found that a telephonic post-discharge process can be effective in reducing readmissions when a standardized intervention focuses on specific solvable problems, an RN performs the triage role, and interventions are delegated to appropriate staff members based on their scope of practice



Abstract 43

A Family Medicine Training Site/Family Nurse Practitioner Doctoral Program Partnership in Quality Improvement Education

Lucille Ferrara, Ed.D., F.N.P., Victoria Gorski, M.D., Robert Burke, F.N.P., Stephen Ferrara, F.N.P., Alicia Fuller, F.N.P., Jacqueline Kelderhouse, F.N.P.

Contact: lferrara@montefiore.org

Members of the Montefiore Department of Family and Social Medicine have a long history of family physician and nurse practitioner collaboration. This foundation enabled the Pace University/Lienhard School of Nursing, Doctor of Nursing Practice (DNP) program to partner in a joint effort for evidence-based continuous quality improvement at Montefiore's Family Health Center (an FQHC). Faculty from both the Montefiore/Einstein family medicine program and the Pace/Lienhard School of Nursing served as mentors, team members, and collaborators in the process. The DNP students, along with key FHC staff, assessed the current state of FHC in terms of organizational strengths and needs, patient strengths and needs, staff knowledge of evidence-based practice, and organizational readiness to change. The DNP students used Appreciative Inquiry to make their assessment. Then, in close collaboration with the Intensive Case Management Team (ICM) for Diabetes, they worked to plan an evidence-based intervention. They conducted a systematic review of the literature that supported the implementation of Group Medical Visits (GMVs) to improve outcomes. Their thorough and thoughtful review of GMVs for diabetes is in review for publication with the Joanna Briggs Institute. Based on findings from the systematic review, the ICM team is working through PDSA cycles for successful implementation of GMVs at FHC. This educational partnership is fulfilling its promise of experiential interdisciplinary QI learning and practice improvement.

Abstract 44

Peer Detailing of a Comparative Effectiveness Module: A Model for CME That Crosses the Continuum

Bob Morrow, M.D., Ellen Tattelman, M.D., Jennifer Purcell, Ph.D.

Contact: rmorrow@montefiore.org

Purpose: We undertook a pilot project to test the use of peer educators to disseminate a Comparative Effectiveness module from the AHRQ to community physicians using an academic detailing model.

A major part of health reform is the systematic evaluation of the comparative effectiveness of different therapies. Dissemination is key: how to bring this to the practice communities? How should outcomes be measured? Continuing education is the start, but Comparative Effectiveness involves the entire medical education continuum.

This interactive project builds on Social Network theory. Peer educators meet providers in their community practices. This network of peer trainers can be involved in other content areas as well.

Interventions & Methods: The trainer training takes two hours, reflecting the focused nature of the educational intervention, and draws on practices of pharmaceutical detailing. The trainers have been drawn from GME and UME faculty of four academic medical centers and residencies, as well as community providers. We have trained 10 trainers, and have started to visit 200 providers in 40 sites, which have been chosen on a geographical convenience basis. The subject area is the use of ACEs/ARBs in stable ischemic heart disease. Usual CME measures of intent to change are used, followed by repeat queries about change. Trainers will be debriefed in group discussions.

Discussion: Prior work demonstrates that peer detailing can activate both faculty and learners to change practice behavior in important ways, and that these changes will also be brought to the resident trainees of the GME faculty at their own workplaces.

Abstract 45

Efficacy of Enabling Service Intervention in an Urban Emergency Department

Eleanor Larrier, M.P.A., C.E.O., Jay Izes, M.D., C.M.O.

Contact: elarrier@montefiore.org

Description: Community health centers provide quality, cost-effective health care, but many community residents are often unaware of this resource. Information about community health centers and health insurance options presented in an Emergency Department in a culturally sensitive manner and combined with enabling service interventions can have a significant impact on reducing non-essential emergency room visits. Research has shown that emergency room patients are more likely to follow-up if they leave with a scheduled appointment. However, many patients need more support. There are many coordination issues to be discussed and resolved between the health center and Emergency Department leadership prior to implementation of a planned intervention. In October 2007, a Performance Improvement Team comprised of Bronx Community Health Network (BCHN), Weiler Hospital Emergency Department (Weiler ED) and Comprehensive Family Care Center (CFCC) leadership and associates sought to improve access for patients referred from Weiler ED to CFCC. In this story board, we present the implemented ED/health center coordinated care model featuring patient intervention by an ED Patient Liaison who offered information about community health center services, facilitated medical and insurance eligibility appointments and followed up missed appointments. Using data for FY 2009, we analyze care-seeking behavior of 1,899 patients six months before, and six months after, the Patient Liaison intervention with patients who did not have a medical home and/or were uninsured, to determine if the intervention resulted in a reduction of ED use and an increase in primary care (health center) use.

Abstract 46

Teamwork and Working at ‘Top of License’ among Staff at Teaching and Non-teaching Ambulatory Practices

Erin Goss, M.D., Jason Fletcher, Ph.D., Claudia Lechuga, M.S., Paul Meissner, M.S.P.H., M. Diane McKee, M.D.

Contact: egoss@montefiore.org

Context: One particularly challenging aspect of practice transformation to a Patient Centered Medical Home involves the transition from a traditional doctor-patient relationship to a team-based approach to care. In preparation for Montefiore Medical Center’s (MMC) transition of its ambulatory sites into PCMH practices, we sought to measure staff perceptions of teamwork. We hypothesized that perceptions of teamwork would be heterogeneous, and are likely to be influenced by the presence of resident trainees at the ambulatory practice, as well as the amount of time spent performing work that fully requires the use of one’s training and skills – ie. working at “top of license”.

Participants: 226 MMC employees responded to the voluntary survey; including physicians, nurses and non-professional staff from two teaching and two non-teaching sites.

Instrument: The survey included two questions regarding the amount of time spent working at top of license as well as Healthcare Team Vitality Instrument (HTVI), a 10-item questionnaire of team vitality for healthcare teams. The 10 questions were grouped into 4 previously validated factors: support structures, engagement and empowerment, patient care transitions, and team communication. Scores for questions relating to a particular factor were averaged to create an overall factor score. Mean factor scores between practices and professions were compared using t-tests.

Results: Compared to non-teaching clinics, teaching clinics scored lower on the HTVI for support structures (3.5 ± 1 vs 3.8 ± 0.9 ; $p < 0.1$) and patient care transitions (3.3 ± 0.9 vs 3.6 ± 0.9 ; $p < 0.05$). Physicians reported the least amount of time spent working at top of license compared to nurses and non-professional staff. Physicians rated access to support structures lower than nursing/ancillary staff and non-professional staff (3.4 ± 0.9 vs 3.7 ± 0.9 and 3.8 ± 1 respectively; $p < 0.05$), but there were no differences between staff and others with regards to the other three factors calculated on the HTVI.

Conclusions: Practices involved in resident education scored lower on measures of support structures and patient care transitions than non-teaching sites. Further investigation is needed to determine why teaching sites report lower levels of teamwork, in order to improve the likelihood of a successful transition to team-based care within a PCMH. Physicians reported more time spent doing tasks that did not require them to fully use their level of training compared to nurses/ancillary clinical staff or non-professional staff; however there was little difference in how these groups rated teamwork at their sites.

Abstract 47

The Intensive Wellness Program for High Need, High Cost Medicaid Patients

Jeffrey Levine, M.D., Oneira Torres, M.P.A., Mercedes Nunez, Ashlyn Hyacinthe, R.N., N.P., Francis Hayden, M.D.

Contact: jlevine@bronxleb.org

Background: Five per cent of patients account for 40% of Medicaid costs. These high need, high cost patients most frequently have combined medical and psychiatric illnesses, usually complicated by substance abuse.

Objectives: To identify primary care patients at high risk for hospitalization and to offer them the “Intensive Wellness Program (IWP)” with multidisciplinary onsite medical and psychiatric care combined with community outreach.

Site: The Martin Luther King, Jr. Wellness Center

Patients: 65 consecutive patients ages 18-64 with Medicaid insurance identified by a risk rating tool, Patients at risk for Hospitalization (PARR) (Billings J, 2006), enrolled at one primary care center. Patients agreed to interviews, questionnaires, and chart review as per IRB approval.

Intervention: Nurse practitioner and culturally competent community health worker supplementing usual PCP care; home assessments; liaison with inpatient care providers; weekly team roster reviews and treatment planning.

Measurements: Hospitalizations, ED visits, and outpatient visits one year before and one year after entry into IWP.

Results: Patients were mean age 48, 57% female, 43% Spanish speaking. Hospitalizations decreased from 137 to 106; ED visits from 152 to 126; neither reached statistical significance. Outpatient visits increased from 1,697 to 2,724 ($P < .01$). Estimated cost savings were \$1,960 per patient. Patients with ≥ 1 hospitalization in the baseline year ($n=45$) showed more robust findings.

Limitations: This is a non-blinded convenience sample with pre/post analysis and without controls. Twenty-one of 65 patients had no hospitalizations in the baseline year, suggesting that patients were not at highest risk.

Conclusion: Intensive team based primary care with community outreach may be cost effective for high cost, high need patients insured by Medicaid.

Abstract 48

Implementing and Sustaining Policies on Obtaining Consents for Treating Minors

Elizabeth Natal, M.D., Jean Burg, M.D.

Contact: Elizabeth.Natal@nbhn.net

Context: Often, an adult other than the parent or legal guardian will accompany a minor to their medical appointment. Without a clear understanding of the policy for consents for treating minors, staff did not consistently obtain necessary and appropriate consents and documentation for proof of identity of the adult accompanying the minor. Chart reviews conducted revealed proper consent and documentation were obtained for 25% of minor-patient visits. This presented potential problems regarding patient safety and liability as, often times, the providers who saw the children ordered and administered treatments, such as vaccines.

Objective: Our goals for this quality improvement measure were to:

1. Develop an understanding of which consents and types of documentation are required when a minor comes for treatment accompanied by a parent or legal guardian, or accompanied by an adult other than the parent or legal guardian.
2. Understand under which circumstances an unaccompanied minor may receive medical care.
3. Maintain 100% compliance with obtaining the proper consents and documentation of identity of the accompanying adult.

Design: We designed an educational intervention incorporating clinician, nursing, clerical, and clinic administration staff. After review of current guidelines, we established a clearly written protocol and outlined the revisions to current standard workflow. The revised protocol was disseminated to staff, patients and parents/legal guardians with a zero-tolerance policy. Further education to parents and legal guardians was provided as needed. Implementation of the written protocol was carried out among all staff members.

Setting: The Health Center at Tremont is located in the Tremont neighborhood of the south central Bronx. It is a community-based HC of the North Bronx Healthcare Network (NBHN), part of the integrated delivery system that includes two New York City public hospitals, North Central Bronx and Jacobi Municipal Hospital Center. The health center is open during the week with 24-hour access to a physician on call. Its staffing model includes 4 family medicine physicians, as well as a social worker, health educator, and nursing staff.

Results & conclusions: A subsequent chart review in February 2011 revealed 90% compliance with the revised protocol and workflow. With adequate education of staff and patients, availability of all appropriate forms, and a zero tolerance policy (minor not seen if proper consents not in place), changes made to protocol regarding parent/legal guardians accompanying minors were able to be implemented and sustained.

Abstract 49

Montefiore Medical Group: Journey to Immunization Excellence

Noel Brown, M.D., MBA, Jon Swartz, MD, MBA, Lisa Stumpo

Contact: nbrown@montefiore.org

In 1997 New York City established mandatory reporting of immunizations to the City Immunization registry (CIR) for all providers who participate in the New York City Department of Health Vaccine for Children Program (VFC). Providers are required to report the status of the dosage received as well as the child's full immunization record. Monitoring of vaccines supplied to participating institutions are based on "Doses Administration Reports" (DAR). The report compares the number of doses reported to CIR to the number of doses distributed by the VFC program during the same period. Compliance is a DAR greater than 80% for full shipment to continue. Lower DAR rates will result in a reduction and eventual termination of supplied vaccines.

In 2010 New York City Department of Health Vaccine For Children (VFC) provided over 4 million dollars worth of vaccine to Montefiore Medical Center ambulatory practices to improve care of children who resides in New York City.

The Vaccine For Children program also requires reporting of the type of vaccination administered to CIR in addition to the number of doses administered. Quarterly, CIR provide institutions with performance data (CIR UTD%) based on the information transmitted to registry for internal monitoring and performance improvement efforts. NYCDOH VFC used CIR generated reports for surveillance and monitoring of the effectiveness of the VFC program.

Montefiore Medical Group's performance (as reflected by the CIR /VFC reports) has been below average when compared to other institutions. Multidisciplinary efforts have been implemented improve reporting accuracies.

Resident Education

Abstract 50

Use of the Electronic Medical Record to Teach Complementary and Alternative Medicine: Whats the Impact?

Ray Teets, M.D., Jennifer Purcell, Ph.D., Andreas Cohrsen, M.D., Jonathan Silberlicht, M.D.

Contact: RTeets@institute2000.org

Rationale: Complementary and Alternative Medicine (CAM) offers symptomatic improvement that could improve patient satisfaction. Although widely used by patients, CAM training is limited in medical education. While our affiliated medical school has an introductory CAM curriculum, the opportunities for using an electronic medical record have not been available yet.

Aims & Objectives: This poster will describe the implementation of CAM training into medical student education utilizing electronic formats, as well as assessment of how this affects students' attitudes and knowledge, with inclusion of a control group. CAM is taught both during clinical encounters, as well as through didactics.

Outcomes: We will look at pre- and post-intervention assessments, with a control group. We will examine any biases and confounding variables in our comparisons and assessments.

Abstract 51

Provider Sexual History Taking Practices at the Bronx Lebanon Hospital Center

Wei Wang, M.D., Jose Tiburcio, M.D., Jose Lopez, M.D., Amir Levin, M.D., Jasmeen Kaur, M.D.,

Contact: wwang@bronxleb.org

Context: Each year, approximately 12 million cases of sexually transmitted diseases (STDs) occur in the United States, including an estimated 1.4 million cases of gonorrhea, 130,000 cases of syphilis, 4 million cases of chlamydia, 500,000 to 1 million cases of human papillomavirus, 200,000 to 500,000 cases of genital herpes, and 45,000 cases of HIV. Studies have shown that nationally physicians consistently underestimate the importance of sexual health care. There is evidence suggesting that effective personal counseling of patients by providers is an important factor in reducing patients' high risk sexual behaviors.

Objective: Studies have shown that the rates of HIV and other STDs in the South Bronx, are considerably higher than the national averages. Therefore taking a proactive approach to comprehensive sexual history taking is all the more important in providing better patient sexual health education, early prevention, disease recognition and treatment.

Design: Common barriers to provider sexual history taking were identified through literature review. A comprehensive 25 question survey questionnaire on provider sexual history taking practices were then compiled.

Setting: After IRB approval, the surveys were distributed to the various departments at the Bronx Lebanon Hospital Center for completion.

Participants: The survey participants were mainly primary care providers and they include residents, attendings, nurse practitioners, and physician assistants from the departments of family medicine, internal medicine, OB/GYN, and pediatrics.

Results & Conclusions: In total 117 providers at the Bronx Lebanon Hospital Center were surveyed. The results showed that the most frequent barriers to effective sexual history taking include, time constraints, fear of patient embarrassment, insufficient sexual history taking training, language barriers, cultural differences, and the presence of a third party. The principal investigators of this project will convene with the various departments to discuss ways of incorporating these findings into physician continuing medical education and resident education to heighten the awareness of comprehensive sexual history taking and thus bring about better patient outcomes.

Community Health

Abstract 52

The ADDOPT study (Acupuncture to Decrease Disparities in Pain Treatment): Feasibility of Offering Acupuncture in the Community Health Center Setting

M. Diane McKee, M.D., Benjamin Kligler, M.D., M.P.H., Arthur E. Blank, Ph.D., Jason Fletcher, Ph.D., Anne Jeffres, D.O.M.

Contact: diane.mckee@einstein.yu.edu

Purpose: To describe enrollment and engagement with treatment for the Acupuncture to Decrease Disparities in Outcomes of Pain Treatment (ADDOPT) trial, a quasi-experimental study testing acupuncture as an adjunct to usual treatment for chronic pain in the urban health centers.

Method: Participants receive care at four Bronx hospital-owned health centers serving low-income families. Physicians refer patients experiencing chronic pain due to osteoarthritis, neck or back pain) for 14 weekly acupuncture treatments; pain and functional status are assessed during a 6 week run-in period before acupuncture, during and post treatment.

Results: Of 400 patients referred, 170 have initiated treatment. The majority of attending physicians have referred, most commonly for back pain (n=103; 60.6%). Participants' average age is 53.9 (SD 14.1); 54.1% are Hispanic; 57.6% are on Medicaid. Half (48%) report "poor" or "fair" overall health. Patients report an average disability score of 74 (SD 27.0) and baseline pain severity on the Brief Pain Inventory of 6 (SD 1.9). Patients have completed a mean of 9.1 (SD 5.6) treatments; 72.4% complete ≥ 5 sessions.

Conclusions: Clinicians in this urban setting have incorporated acupuncture into chronic pain management. Despite disability and lack of familiarity, patients initiate acupuncture and show high levels of engagement with treatment.



Abstract 53

Population Health and Primary Care

Alice Beckman, B.A., Lily Chesnut, B.A., Arthur E. Blank, Ph.D.

Contact: abeckman@montefiore.org

The Office of Community Health is working with the New York City Department of Health to create health zones for two primary care practices - West Farms Family Practice and the Family Health Center. The aim of these projects is to examine not only how to improve the health of the patient population but the health of the community which surrounds the West Farms Family Practice and the Family Health Center clinics. In preparing for these efforts the Office of Community Health sought to describe, based on clinical data and public use data, the health of these communities. What is represented in this poster is the information on the health and demographics of the community, as well as the clinic population at the Family Health Center. The poster presents an analysis of the health issues of our clinic population at FHC and compared it with the health issues of the surrounding population. With this information we hope to understand how the needs of those we are currently serving compare with those individuals not currently in our system. Comparing demographics shows us to what degree our patient population is a representation of the larger community they are in. This information will help us to identify the health issues the Office of Community Health and the NYC Department of Health will target, and allow us to plan and assess the impact of large-scale interventions.

Abstract 54

An analysis of the food environment in Bronx, NY: a focus on street vendors

Sean C. Lucan, M.D., M.P.H., Gustavo Hernandez, B.A., Monica Varona, B.S.

Contact: selucan@montefiore.org

Background: Food vendors available in an area can influence people's dietary patterns and overall health. In the Bronx, where diets are poor and diet-related diseases like obesity and diabetes are prevalent, street food vendors may be a particularly important influence, but have been neglected by past research.

Objective: To ascertain the number of street food vendors in the Bronx, the types of foods and drinks they sell, and the preferred language of vendors.

Methods: Researchers drove all the streets in the Bronx using Google Maps and identified, observed, and interviewed street-food vendors

Results: Most vendors (52%) sold ice cream and processed frozen treats. Vendors that sold prepared foods offered no healthy options. No vendors sold milk, and many only offered drinks with calories. Even produce vendors often sold processed foods. 79% of vendors preferred Spanish when speaking.

Conclusion: Most vendors sell unhealthy items. Most vendors are most comfortable speaking Spanish. Future research should further explore the foods and drinks offered at through street vendors, making use of Spanish-speaking interviewers, and linking food offerings to people's dietary patterns



Abstract 55

“Taxi!” Health Outreach for South Asian Cab Drivers

Zehra Siddiqui, D.O.

Contact: zahra82@gmail.com

Providing healthcare in a society with people from many different ethnic and cultural backgrounds can be challenging and access is not the same for all. Immigrant populations have many barriers to getting “plugged in” to the health care model for many reasons. This project aims to reach a population that is at high risk for cardiovascular disease by seeking to understand their barriers and initiating outreach projects. This storyboard outlines a project where we went to a location frequented by cab drivers, offered health screenings which included checking BMI, Blood pressure, Cholesterol – LDL, HDL, and blood sugar followed counseling on nutrition and exercise. Around 45 people were given health information, 20 people had screenings, 6 people were identified with abnormal results and without a primary care physician that were given appointments in resident clinic.

Other

Abstract 56

A resident-driven approach to systems-based practice education and innovation at a primary care medicine ambulatory teaching clinic

A. Stark; A. Kriegsman; H.V. Kunins; J. DeLuca

Contact: astark@montefiore.org

Needs and objectives

Although the Accreditation Council for Graduate Medical Education (ACGME) requires physicians-in-training to achieve proficiency in Systems-based Practice (SBP), one of six domains of physician competency, few effective training methods have been described. The ACGME defines SBP as the ability to identify, evaluate and utilize health care system resources to provide optimal care. SBP is especially important in internal medicine residency programs, where residents have fragmented schedules and competing commitments. The emergence of the Patient Centered Medical Home (PCMH) model, with its emphasis on optimizing resources and team based care, presents an opportunity to engage residents in SBP while fulfilling ACGME educational objectives and improving patient care. To this end, we designed and implemented a resident-driven educational program to improve resident competency in SBP, and provide an ongoing forum for discussion, education and innovation at our ambulatory teaching clinic.

Setting and participants

The continuity clinic of the Primary Care and Social Internal Medicine Residency Program at Montefiore Medical Center is located at the Comprehensive Health Care Center (CHCC), a multi-disciplinary Federally Qualified Health Center in an indigent neighborhood in the South Bronx. CHCC is the sole ambulatory site for thirty residents (PGY1-3), one chief resident (PGY4) and 18 attending physicians. CHCC is one of 22 Montefiore Medical Center ambulatory sites and is targeted for inclusion in the institutional effort to obtain PCMH certification.

Description

During the academic year 2010 - 2011 we initiated an iterative educational process to engage residents in a dialogue about SBP. An anonymous web-based survey was sent to all 19 PGY2 and 3 residents asking them how they would handle four common clinical scenarios that occur when the resident is not in clinic or between patients' clinic visits: (1) following up of critical lab values; (2) scheduling non-routine follow-up appointments; (3) handling urgent care situations when patients call from home; and (4) titrating medications. Each scenario was derived from our clinical experience and piloted with colleagues prior to survey distribution. Results were analyzed and a set of best practices was created. At a program-wide retreat attended by approximately 25 residents and faculty we moderated a two-hour discussion on the survey results, best practices and other SBP topics identified. A second anonymous survey was sent to the same 19 residents assessing the value of monthly SBP meetings.

Evaluation

Seventy-four percent (14/19) of residents responded to the initial survey, with up to 5 solutions given for each scenario. Responses varied by the skill level of the clinic staff member asked to assist with the task, the number of phone calls, emails, and hand-offs required, and the time needed for task completion. Given the heterogeneity of responses a set of best practices, emphasizing non-physician resources, was created and disseminated. Our second survey used a 5-point Likert scale (5=Quite Valuable, 1=No Value) to quantify the value of monthly SBP discussions. One hundred percent (14/14) of responders reported that sessions would be "valuable" or "quite valuable." We then initiated monthly discussions (60-75 minutes) during ambulatory blocks (4-8 residents/month). To date we have held two sessions. Prior to each session we solicit SBP topics and distribute a resident derived agenda. Afterwards, we email key takeaway points and post updates on our program's searchable website.

Discussion

The development of a resident-driven process to address SBP is feasible, meets ACGME requirements, and provides an opportunity to optimize care at a primary care teaching clinic. Through our program, residents learn about the elements of SBP, collectively evaluate clinic processes, assume a stakeholder role in the functioning of their clinic, and facilitate the improvement of patient care. Our iterative process allows us to craft agendas for monthly SBP meetings based on real-time issues as defined by residents. These have included the making and tracking of timely referrals, incorporating non-MD providers into the management of chronic diseases, planning for the electronic medical record, and effectively managing and communicating with patients between visits. We have found that our residents are invested in SBP and are eager to engage in discussions to evaluate systems and implement change. The process will become increasingly beneficial as our clinic evolves into a certified PCMH.