2023

COMMUNITY HEALTH INSTITUTE

NATIONAL ASSOCIATION OF
Community Health Centers®

CHI & EXPO

Manchester Grand Hyatt, San Diego, CA
Conference: August 27–29 | Committee Meetings: August 25–26
HYBRID

Poster Presentation Guide

*The 2023 CHI & EXPO Poster Presentations are
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Poster Presentations

Sunday, August 27, 2023, 5:00pm – 6:30pm
Monday, August 28, 2023, 12:30pm – 1:30pm

Harbor Foyer

The Community Health Institute (CHI) & EXPO is the ideal place to learn about current health center research activities and innovations. The 2023 Poster Presentations provide a unique opportunity to exchange ideas, problem-solve, and network with colleagues. Discover the results of innovative research initiatives and enjoy the opportunity to ask in-depth questions. To provide ample time for poster review, the 2023 Poster Presentations are scheduled for both Sunday and Monday during the CHI. Presenter attendance is required for Sunday, and strongly encouraged for Monday's presentations.

2023 NACHC Poster Presentation Awards

There are 39 posters, including 9 A.T. Still University posters, to be presented during the 2023 poster session. YOU will choose the Best in Show posters! Vote for your favorite *Clinical Practice Innovation, Health Center Workforce Strategies, and Research* posters on the NACHC Mobile App by clicking on "Vote for the Best Posters." When judging poster presentations, please consider the following criteria: innovation of information, presentation of poster, relevance of topic, impact of findings, replicability of innovation, and value of information to other health centers.

All poster voting MUST be completed by 3:00pm on Monday, August 28.

When voting, refer to the conference program for instructions on downloading the app.

All 2023 CHI Poster Presentation winners will be announced during Tuesday's general session.

Prizes will be awarded to the TOP three winners in each category of *Clinical Practice Innovation, Health Center Workforce Strategies, and Research*:

First Place: $250 AND a Complimentary Registration for the 2024 CHI & EXPO!

Second Place: $150

Third Place: $100

A.T. Still University (ATSU)

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

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

National Center for Community Health Research

NCCHR

Poster Categories

The poster presentations are organized by the following categories: *Clinical Practice Innovation, Health Center Workforce Strategies, and Research.*

Clinical Practice Innovation

CP1 Empowering West Oahu Youth to Invest in their Mental Health Post-COVID-19

CP2 Mailing FIT Kits to Improve Colorectal Cancer Screening Rates

CP3 Closing Disparities in Hypertension Control in the Black/African American Population

CP4 The Integration of HCV Treatment into Ohio FQHC Primary Care and SUD Visits

CP5 An Integrated Approach to Increase Colorectal Cancer Screenings Through Pharmacy Home Delivery and Clinical Research - **WITHDRAWN**

CP6 The Development of Nutritional Solutions for Pacific Islander Populations with Resource Limitations

CP7 Improving Eye Exam Screening Rates for Patients with Diabetes by Using Autonomous AI at Point-of-Care Solutions

CP8 The Financial Feasibility of a Clinical Pharmacy Program at a Community Health Center in North Carolina

CP9 A Toolkit: Improving Linkages Between Sexual and Reproductive Health Settings and Substance Use Service Sites - **WITHDRAWN**

CP10 A Multi-Strategy Approach to Cardiovascular Health Improvement in an Urban Health Center Network: Success, Challenges, and Sustainability

CP11 Color Your Plate: Addressing Economic, Educational, and Nutritional Determinants of Health in Low-Income Communities

CP12 Innovative HIV PrEP Delivery Among Diverse Communities at an FQHC in Seattle, Washington

CP13 Using Data to Drive Clinical Quality Improvement Data

Health Center Workforce Strategies

CP14 California's Central Valley Physician Shortage: An Inside Perspective

CP15 Diversity and Inclusion in FQHC Workforce: Importance of Investing in Staff Development for Equity

Research

CP16 Improving Health Literacy in High School Students

CP17 Building Research Capacity Within Federally Qualified Health Centers

CP18 Let's Get REAL: Improving Race, Ethnicity, and Language Data Collection at Denver Health

CP19 A First Look at All of Us Research Program Retention for Participants Without Housing or with Insecure Housing

CP20 The Way Forward Toward Health Equity in 2025

CP21 A Data-Driven Approach to Understanding Factors Contributing to Health Inequities Among Community Health Center Patients

CP22 Do You See Your Bias? Accent Perception in the Healthcare System

CP23 The Impact of FQHC Penetration on COVID-19 Mortality in Four United States Cities

CP24 The Maternal Medical Home in FQHCs: Increasing Continuity of Care to Reduce Maternal and Infant Mortality Risk

CP25 Provider Perceptions of Clinical Pharmacy Services at Federally Qualified Health Centers in Ohio

CP26 Addressing Food Insecurity by Increasing Knowledge of Local Food Pantries at NYU Langone Family Health Centers

CP27 Evaluating the Impact of a Digital Health Promotion Intervention on Outpatient Substance Use Disorder Treatment Engagement

CP28 Critical Analysis of Transition Services Program for Management of Opioid Use Disorder and Its Future Improvements in Multnomah County

CP29 The Impact of the Pandemic on Federally Qualified Health Center Patients with Type II Diabetes: A Case Study

CP30 Asian Americans' Approach to Behavioral Health

CP31 Using Data Visualization to Assess Maternal Health Care Delivered at Federally Qualified Health Centers - United States, 2021

CP32 Estimates of Visits for Mental Health and Substance Use Disorders at Federally Qualified Health Centers - United States, 2021

CP33 The Association of ACE Scores and Chronic Health Outcomes Among Patients with Chronic Pain Using Behavioral Health Interventions

CP34 Stress and Resiliency Strategies Among Health Professions Students

CP35 Differences in Documenting Social Drivers of Health in Electronic Health Records

CP36 Understanding Clinician Engagement in the Patient Scheduling Process

CP37 Exploring Clinician Attitudes, Knowledge, and Practices Related to Contraceptive Prescribing at a Federally Qualified Health Center in Arizona

CP38 Hispanic Community Outreach Impact on Increasing Hispanic Participation in the All of Us Research Program - Columbia, SC, 2022-2023

CP39 Latent TB Infection Care Cascade at a Community Health Center in Seattle

Clinical Practice Innovation

CP1

Empowering West Oahu Youth to Invest in Their Mental Health Post-COVID-19

Poster Type: Clinical Practice Innovation

Description: The purpose of this project is to empower adolescents to invest time and effort into maintaining their mental health and educate them about the resources available in West Oahu communities. A holistic approach to mental health curriculum was created and offered to all 87 ninth grade students at DreamHouse High School. The 4-week curriculum included one-hour sessions taught once per week covering topics such as the Waianae Coast Comprehensive Health Center (WCCHC) Resources, Native Hawaiian Healing Practices for Mental Health, Nutrition and Mindfulness, and the Osteopathic Approach to Mental Health. After the conclusion of the curriculum, the students were invited to complete a survey to assess their understanding of the curriculum topics. The data from the survey were analyzed to assess their understanding of and perceptions about the material presented.

Principal Findings: Of the 87 participating students, 44 (51%) completed the survey:

- 89% of students agreed or strongly agreed that they recognize the importance of community health centers in providing mental health services.

- More than 75% of the students agreed or strongly agreed that they have a better understanding of resources for mental health, including lomi-lomi. While 43% of the students answered "Yes" to feeling more connected to Hawaiian cultural practices. When asked to elaborate on how they feel connected, 67% of the short responses discussed the application of Native Hawaiian practices in healing as well as feeling connected to ancestors.

- 90% of students agreed or strongly agreed that they can recognize unhealthy drinks.

- 90% of short responses on the usefulness of mindfulness techniques discussed how these techniques encourage stress reduction and relaxation.

- 73% of students agreed/strongly agreed that they have an understanding of what osteopathic medicine can do for mental health.

How this Project/Study Benefits Health Centers: The holistic approach to mental health curriculum was successful in educating ninth graders at DreamHouse High School on the importance of community health centers, available mental health resources, Native Hawaiian healing practices, and healthy diet when addressing mental well-being. Nuanced concepts like osteopathic medicine, allopathic medicine, and lomi-lomi were introduced, however, reinforcement of these topics may be necessary. The results may not be representative of the entire West Oahu population, as the scope of this study was limited. Further studies with increased participant diversity are needed to gauge the success of this curriculum.

Learning Objectives:

- Understand the need for mental health education for adolescents in West Oahu communities.

- Discuss how this Holistic Approach to Mental Health curriculum was successful in educating adolescents on the various types of available mental health resources.

- Evaluate how future studies can be designed to have a greater impact on adolescents in West Oahu communities.

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[1]A.T. Still University-School of Osteopathic Medicine in Arizona

Presenter(s): Sabrina Katz, Stephanie Cacal, Gilbert Dang, Rowena Feng, Christina Nielsen, Vivian Vo

CP2

Mailing FIT Kits to Improve Colorectal Cancer Screening Rates

Poster Type: Clinical Practice Innovation

Description: Colorectal cancer is a major cause of morbidity and mortality in men and women in the US and effective methods of early detection include FIT testing. Despite effective methods in engaging patients in completing colorectal cancer screenings, we can still see disparities in screening completions. During the pandemic, colorectal cancer screening plummeted at Denver Health to a low of 53.7%, widening the gap, especially for those populations who had a harder time accessing healthcare services. Traditionally, medical homes have provided FIT testing kits during office visits but during the pandemic patients stopped coming for in-office visits. We thought of this as an opportunity to test the opportunity to mail out FIT kits to those patients who were engaging with the healthcare system.

Principal Findings: Over 15,000 patients eligible for inclusion in the pilot, 3674 patients were sent a FIT kit using ARPA funding. Among the exposure group, 35.0% had 1 or more recorded FIT results in 2022, compared with 15.7% of the unexposed group. After adjusting for sex, age, race and ethnicity, preferred language, type of insurance coverage, and count of primary care visits in 2022, patients who received a FIT kit in the mail were 2.44 times more likely to have a recorded FIT result, compared to patients who did not receive a FIT in the mail. Our colorectal cancer screening rates jumped to 60.9% following this intervention.

How this Project/Study Benefits Health Centers: Colorectal cancer screening is one of the UDS metrics all community health centers need to submit, and learning about innovative population health strategies will benefit them. This promising practice could be easily implemented at different community health centers.

Learning Objectives:

▪ Understand the impact of mailing out FIT kits to patients as a strategy to improve colorectal cancer screening.

▪ Understand the process of how to effectively systematize mailing out FIT kits from the medical home.

▪ Observe the different innovative patient education materials used during this intervention, including QR codes linked to videos and transcreated letter templates.

Author(s):
Maria Casaverde Marin, MHA, Clinical Quality Operations Manager, Denver Health and Hospital Authority

Presenter(s): Maria Casaverde Marin

CP3

Closing Disparities in Hypertension Control in the Black/African American Population

Poster Type: Clinical Practice Innovation

Description: The Denver Health Equity Blueprint is our three-year road map to advance diversity, equity, and inclusion within Denver Health and our community. One of the goals was to measure, identify and improve health equity and outcomes. Hypertension is one of the five key clinical outcomes where we have found disparities between our population of color and the whole patient population. Denver Health set out to prove that with the right interventions, disparities in hypertension for the Black patient population could be closed. Hypertension is a chronic disease condition that impacts nearly 15% of our Denver Health patient population. That's around 28,000 patients. While the Hispanic population is the largest patient population with hypertension, the Black population has the greatest disparities of hypertension control rates in comparison to other populations. In February 2022, Denver Health's population health team initiated a new project in collaboration with Webb adult clinical pharmacists aimed at proving that hypertension control rates can be improved in the clinic's Black adult patients. Historically, the Webb adult clinic had the lowest control rate as of January 2022 (53.4%). To initiate the pilot, a team made up of a medical assistant, pharmacy technician, clinical pharmacist, and the patient's primary care provider identified nearly 300 Black patients at the Webb clinic whose last clinic blood pressure reading was above 140/90. Through the implementation of this pilot that lasted 6 months, we used team-based care concepts to develop a workflow that guided the patient to the right resource provider to address medication adherence barriers and educate patients on self-management tools. The intervention also effectively utilized

home monitoring devices and supported patients in sharing their numbers over our patient portal.

Principal Findings: The pilot outcome showed improvement in hypertension control in the Webb Black population by over 11.5 percentage points in five months and erased the health disparities gap between Blacks and Whites in hypertension control. During this time, all racial groups improved as well. While the pilot was successful, Denver Health is still struggling to operationalize this process across our system and it's a challenge we are still working through.

How this Project/Study Benefits Health Centers: Disparities in hypertension control have been tracked over years without clear solutions. Our pilot project not only showed results but also effective use of resources and the application of team-based care concepts. Although we have not operationalized these processes across our system, our pilot shows significant improvement and decreasing disparities between our minority populations.

Learning Objectives:

▪ Understand the effective utilization of clinical pharmacists in hypertension programs using team-based care concepts.

▪ Discuss medication adherence program in community health centers to support better hypertension control in Black/African American populations.

▪ Identify the different challenges in the implementation of this program and Denver Health's plan to address these problems.

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Presenter(s): Maria Casaverde Marin

CP4

The Integration of HCV Treatment into Ohio FQHC Primary Care and SUD Visits

Poster Type: Clinical Practice Innovation

Description: This project was part of my Midwest Family Practice Primary Care Champions Fellowship work. It was conducted in the context of a high-risk SUD patient population at an urban FQHC in Columbus, Ohio. The patient population involved over 200 predominantly homeless individuals who were still actively using substances and were coming to the FQHC for suboxone/MOUD. In this context, we tested the effectiveness and feasibility of integrating treatment for chronic hepatitis C as part of the patients SUD care visits. Workflow and clinical training for providers were evaluated and tested. The results of both best workflow and best training were then translated into primary care visits as well. Finally, the workflows, protocols, training and other resources were compiled into an FQHC play book to spread and share with other Ohio FQHCs.

Principal Findings: Seven states (Florida, Indiana, New York, Ohio, Pennsylvania, Tennessee, and California) represented more than half of all reported cases of acute hepatitis C nationally in 2019 - and four of the seven states are in Appalachia. (Source: CDC Fact Sheet) Only a fraction of those with chronic HCV are receiving treatment annually. This means they are at risk for cirrhosis, liver cancer, and death, as well as infecting others. HCV is one of the most common causes of liver failure. New medications have made treating HCV quick, efficient, effective and doable in many health care settings. Yet the process for accessing treatment through specialist remains inefficient and cumbersome. There is a need to expand HCV treatment into FQHC primary care and SUD treatment settings. In our over 200 patients, over 70% of them had untreated HCV. Data from the beginning year (2021) shows that only 5% of patients being referred for HCV treatment kept the appointment, and then only 1-2% were completing treatment and achieving SVR or cure. After the implementation of direct treatment as part of the patient's FQHC SUD visit, data now shows that 86% of the patient cohort have started treatment, and 56% have already achieved SVR or cure as of Feb 2023.

How this Project/Study Benefits Health Centers: This project allowed for identification of best practice workflows and provider champion/prescriber clinical training along with the development of an FQHC playbook for Integration of Hepatitis C Treatment directly at the FQHC. The learning and tools will benefit all FQHCs in more effectively getting patients treated and cured.

Learning Objectives:

- Elevate best practice workflows in health center primary care and substance use disorder visits to integrate direct treatment of hepatitis C.

- Understand a prescriber training plan for clinical training in hepatitis C management.

- Review impact of integration of hepatitis C treatment in the FQHC to efficiency of care and overall treatment outcomes.

Author(s):
Dana Vallangeon, MD, Chief Medical Officer, Ohio Association of Community Health Centers

Presenter(s): Dana Vallangeon

CP5

An Integrated Approach to Increase Colorectal Cancer Screenings Through Pharmacy Home Delivery and Clinical Research - WITHDRAWN

CP6

The Development of Nutritional Solutions for Pacific Islander Populations with Resource Limitations

Poster Type: Clinical Practice Innovation

Description: This project aimed to develop culturally competent nutritional information tailored to underrepresented populations residing in King County. Healthy recipes, nutritional resources, and portion control information were created to modify existing dietary practices and encourage dietary intake moderation. The goal was to empower and promote healthier eating habits among these communities while providing them with realistic ways to make improvements to their overall health.

This quality improvement project required that participants be 18+ years of age, reside within King County, and identify as Pacific Islander. Community-based intervention was implemented at the initial meeting where participants received a brief education on dietary lifestyle. They were provided with healthy, freshly cooked, culturally relevant food samples. Additionally, individuals were provided educational pamphlets containing information on balanced portion sizes from MyPlate (USDA), heart-healthy recipes, and diabetes-friendly foods for home use. To gauge effectiveness, an initial survey was distributed to evaluate participants' food intake, nutritional habits, and willingness for diet-friendly resources. After two weeks, the same participants completed a follow-up survey. Both surveys were compiled and analyzed. This approach allowed us to monitor and evaluate the impact of our intervention on the participant's dietary habits and identify areas where the approach could be improved in the future. Follow-up surveys asked about implementation of recipes, future use of recipes, and if dietary modifications were utilized from the information provided. Participant resource utilization was evaluated on follow-up surveys based on willingness to try prepared foods and improve factors such as weight management, diabetes, and hypertension control. Evaluation of the project is based on the ability to disseminate information, response from the patient population, and implementation of diet modifications. These were assessed by the number of individuals counseled, survey responses, and self-reported motivation to make healthy improvements to lifestyle and diet.

Principal Findings: At the community initiative, 17 individuals were present: 10 were eligible to complete initial surveys, of which, 6 completed follow-up surveys (Response Rate = 60%). Follow-up participants had no reported diagnosis of hypertension, diabetes, or prediabetes. Meat consumption included only red meat and poultry. Daily reported consumption of vegetables and fruits increased by 50% and 83%, respectively; 50% of respondents started or increased the practice of measuring food portions; and 83% stated the information provided helped them improve dietary choices and were interested in further education. Written responses from participants expressed desire for educational resources that contrast the bodily effects of

cultural foods on overall health with an emphasis on balancing cultural foods rather than changing to alternative foods. Participants felt the use of the MyPlate diagram to visualize healthy and balanced portion sizes was effective at conveying the goal of healthy proportions over changing cultural foods.

How this Project/Study Benefits Health Centers: According to the survey responses obtained from this population, there was a preference for nutritional information and counseling that emphasize cultural foods, while maintaining patient autonomy in diet modifications. Furthermore, the respondents desired to avoid switching to foods that are typical of western-based diets or the removal of cultural foods. Examples of healthy cultural dishes and visual representation of balanced portion sizes, such as the MyPlate diagram used in this study, were impactful. Overall, responses indicated desire for participant autonomy over being told what actions need to be taken for their health. This suggests the importance for motivational-interviewing and culturally-sensitive modifications to be incorporated into healthcare centers to meet the needs of Pacific Islander patients. After presenting this project at an academic seminar and within the community, it is anticipated to bring awareness to how healthcare is more effective when individualized to the patients' identity and resources.

Learning Objectives:

- Develop appropriate nutrition plans based on patients' cultural backgrounds.

- Implement proportion-based dietary modifications rather than change dietary foods.

- Maintain patient autonomy in diet modifications with appropriate motivational interviewing techniques.

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Presenter(s): Mallory Zembower, Adam Martorana

CP7

Improving Eye Exam Screening Rates for Patients with Diabetes by Using Autonomous AI at Point-of-Care Solutions

Poster Type: Clinical Practice Innovation

Description: Diabetic retinopathy (DR) is a vision-threatening complication of diabetes. Over 75% of people living with diabetes will develop DR, the leading cause of preventable blindness across the US. Early detection is critical and current guidelines recommend an annual screening eye exam for diabetes (EED). Zufall Health Center (ZHC) is a Federally Qualified Health Center (FQHC) that provides high-quality, culturally competent primary health care to underserved, majority Latino and uninsured adult residents across seven counties in New Jersey. In April 2021, at four of our sites, baseline data showed that 16.0% (314/1,904) of patients with diabetes had completed an annual EED.

Principal Findings: From April 2021 to April 2023, 475 patients were provided autonomous AI exams. Of those, 259 tested negative for DM, thereby reducing the number of referral to eye specialists; and 88 patients tested positive and were provided prompt referrals. EED rates at ZHC doubled to 32%.

How this Project/Study Benefits Health Centers: Completion rates for an annual EED across various health systems range from 15% to 50%, and are lower at many FQHCs where multi-factorial barriers to referral completion exist. With the addition of an autonomous AI point-of-care solution at ZHC, rates for annual EED doubled. Patients testing positive receive immediate referrals allowing for prompt attention and potentially vision saving treatment. Identifying vision-threatening organ damage also provides crucial feedback for the patient and medical team regarding the need for intensifying or improving overall DM care. For health centers looking to provide autonomous AI technology for the detection of DR, this project can serve as a road map for implementation.

Learning Objectives:

- Describe how autonomous AI systems are used to improve access to EED at point-of-care.

- Discuss the impact of autonomous AI on completion rates for annual eye exams for diabetes.

- Predict how autonomous AI could impact workflow and resources at your health center.

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Presenter(s): Rina Ramirez

CP8

The Financial Feasibility of a Clinical Pharmacy Program at a Community Health Center in North Carolina

Poster Type: Clinical Practice Innovation

Description: Despite evidence that clinical pharmacy services improve patient outcomes, increase medication adherence and optimize drug therapy plans, integration of clinical pharmacist practitioners (CPPs) can be financially challenging for community health centers given the lack of reimbursement by third-party payers. Creating and maintaining CPPs is financially justified with the 340B savings from prescriptions written by these practitioners.The objective of this study is to describe a financially sustainable model of clinical pharmacy services at Appalachian Mountain Community Health Centers (AMCHC).

Principal Findings: AMCHC, a federally-qualified health center serving over 13,000 patients annually across Western North Carolina, developed a clinical pharmacy program and integrated two full-time equivalent (FTE) CPPs over two years. The employer contributes approximately $13,500 monthly in salary and benefits for one FTE-CPP. On average, one CPP-FTE generates $107,867 in 340B savings monthly, derived directly from prescriptions written. Additionally, each CPP-FTE provides an average of $16,000 monthly in cost avoidance by clinical interventions such as optimizing medication regimens, improving clinical outcomes, and preventing adverse drug reactions.

How this Project/Study Benefits Health Centers: Adverse drug events and medication errors are a leading cause of hospitalization and death in the United States. Given an increasing number of medications commercially available, rapidly changing evidence that informs clinical guidelines and a growing number of elderly patients, there is a need for integration of clinical pharmacist practitioners in primary care. CPPs offer a unique knowledge of medication therapy management and are extensively trained in the doctoral program to provide empathetic, thorough patient education. CPPs have specialized training beyond chronic disease management and often oversee patient assistance programs as well as educational services. The exclusion of CPPs from the primary care team leaves practices at risk of medication errors and patients at risk of harm. AMCHC has demonstrated that despite limitations in existing reimbursement models, 340B savings derived directly from CPPs financially justifies their addition into the primary care team.

Learning Objectives:

- Recognize potential 340B savings directly attributable to clinical pharmacist practitioners integrated into primary care.

- Describe cost avoidance supported by clinical pharmacist practitioner interventions.

- Identify barriers and develop solutions for incorporation of a clinical pharmacist practitioner.

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[1]Appalachian Mountain Community Health Centers

Presenter(s): David S. Taylor, Shawn Riser Taylor

CP9

A Toolkit: Improving Linkages Between Sexual and Reproductive Health Settings and Substance Use Service Sites- WITHDRAWN

CP10

A Multi-Strategy Approach to Cardiovascular Health Improvement in an Urban Health Center Network: Success, Challenges, and Sustainability

Poster Type: Clinical Practice Innovation

Description: The Health Federation of Philadelphia (HFP), a Health Center Controlled Network, has collaborated with the Philadelphia Department of Public Health and six member FQHCs over the past five years to improve cardiovascular health among Black/African American adult patients, with funding from the Centers for Disease Control, through the "Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke" program (CDC 1817). Strategies have included expanding and training the care team - including behavioral health consultants, community health workers, medical assistants, and pharmacists; development of process and outcome-focused data dashboards using population health tools with quarterly data reporting to each health center; development and application of customized documentation and clinical decision support in EHRs and population health tools; use of an electronical social needs referral platform; and implementation of self-monitored blood pressure programs. This poster will focus on the successes, challenges, and lessons learned from this project, including the impact of the COVID pandemic and subsequent pivot to telehealth, which resulted in a loss of blood pressure measurements and challenges to understanding the health status of this vulnerable population. The HCCN and health centers utilized various strategies to manage through the pandemic, which will be explored in the poster, along with the dramatic data showing the impact of missed blood pressure measurements and recovery, as care moved partially back into the clinics.

Principal Findings: HFP and its health center partners found that key team members to support patients in managing hypertension include behavioral health consultants, medical assistants, community health workers and pharmacists, alongside providers. Specialized training is needed for all team members to reinforce the focus on their role in improving

cardiovascular health. Key interventions included a clinically linked self-monitored blood pressure program, tailored documentation and data reporting, and behavioral health support aimed at lifestyle change and medication adherence. Consistent focus on hypertension control as a clinical priority and quarterly review of data, including racial/ethnic disparities, was also key to success. Blood pressure control rates dropped dramatically during the pandemic, largely due to missing measurements. Post-pandemic, control rates have recovered and even exceeded pre-pandemic rates, though many challenges remain. All interventions were designed to be sustainable within health centers without continued grant funding, by strengthening existing care team capacity and integrating the focus on hypertension control into tools routinely used by FQHC teams.

How this Project/Study Benefits Health Centers: A number of resources that can be utilized by other health centers and health center networks were developed through this project, including a toolkit for behavioral health professionals on working with hypertensive patients, an online training module for medical assistants on their role in the care team related to hypertension, data dashboards that were used to highlight both process and outcome metrics and to closely monitor improvement progress, and a framework for implementing self-monitored blood pressure programs in health centers.

Learning Objectives:

- Identify key strategies for improving cardiovascular health in an urban, FQHC population.

- Analyze the impact of the pandemic on blood pressure data and control.

- Propose tools for supporting health center staff in optimizing blood pressure care.

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[1]Health Federation of Philadelphia

Presenter(s): Suzanne Cohen

CP11

Color Your Plate: Addressing Economic, Educational, and Nutritional Determinants of Health in Low-Income Communities

Poster Type: Clinical Practice Innovation

Description: To address the deep-rooted economic, nutritional, and educational social determinants of health (SDOH) in the heavily Hispanic, low-income Rio Grande Valley of Texas, Su Clinica received a $50,000 grant from It's Time Texas/Blue Cross Blue Shield of Texas. The Rio Grande Valley is one of the state's poorest regions. Uninsured rates among the adult population are at 30%, three times the national average of 10%. With me-dian household incomes of $38,758, over 25% live in poverty. In a region that is 91.6% Hispanic, it is estimated that 27% of the adult population has diabetes while another 32% have pre-diabetes. The project targeted 200 uninsured, low-income patients with a diagnosis of diabetes and obesity to demonstrate that the elimination of relevant nutrition-related determinants can lead to changed eating and lifestyle habits. The clinic set out to answer the question: In one of the poorest regions of the country, could we educate our diabetic and obese patients to eat more fruits and vegetables instead of more fast food? Collaborating with the state's largest retail grocer, H-E-B, clinic providers counseled patients on nutrition, wrote prescriptions for healthy eating, and provided $50 fruit and vegetable coupons that were redeemable at the grocery store. Patients were eligible for up to three clinic visits and three coupon packets. To address economic barriers, the patient's nominal fee was waived for program-related visits and transportation vouchers were also provided where appropriate. The clinic's Social Services Department "Care Coaches" addressed educational determinants by producing a bilingual cookbook with low-cost, culturally appropriate, healthy recipes and by providing cooking lessons and classes for participants. A nutrition advisory committee was also established. H-E-B dietitians also provided nutrition advice to patients and managed the coupon redemption. Patients were given a "Your Pathway to Health" booklet to track their progress and a certificate of completion at the end of the project. Care Coaches conducted patient surveys throughout the program and collected trend data on fruit and vegetable consumption.

Principal Findings: The clinic found that addressing social determinants through a focused effort, related to healthy eating, did have a positive impact on patient engagement. The 200 program patients participated in 480 clinic visits and redeemed 460 coupons for fruits and vegetables. Care Coaches interacted with the patients through 647 educational encounters. Over the course of the program, patient surveys showed that fruit servings per week increased from 7.67 to 12.87 and vegetable servings per week increased from 8.2 to 13.83. Collaborating with a highly respected retail partner (H-E-B Grocery) and leveraging support from other statewide, well-known brands (It's Time Texas/Blue Cross Blue Shield of Texas) gave the project a level of professionalism and credibility that contributed to positive patient engagement.

How this Project/Study Benefits Health Centers: Helping health center patients adopt new, healthier habits may reduce chronic conditions by the simple change of incorporating more fruits and vegetables in their daily life. The interventions taken by the clinic were relatively low cost, but had a high impact on: increasing patient engagement and bringing increased joy to the workplace for staff who produced the cookbook and worked with the participants. The clinic used the expertise of the in-house dietitian for healthy recipes and the in-house marketing department for program marketing to reduce costs for the project. Corporate partners produced the coupons and handled coupon fulfillment at the point of sale. Once the logistics were worked out, coupons instead of vouchers were wildly popular with our patients. Leveraging the expertise of

our statewide partners brought new ideas to the table and greatly accelerated what we were able to do in one of the poorest regions of the country. Partnerships are powerful!

Learning Objectives:

- Addressing economic, nutritional, and educational social determinants at the patient level can have a positive impact on patient engagement and lifestyle changes.

- Corporate partners are actively aware and engaged in addressing mid-stream social determinants of health and can be great ambassadors of change by contributing creative ideas, marketing expertise, and community branding support.

- Advance health equity by focusing on actionable tips that are sensitive to local culture, income levels, and ethnicities.

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Presenter(s): Cheryl Sproles, Javier Vazquez

CP12

Innovative HIV PrEP Delivery Among Diverse Communities at an FQHC in Seattle, Washington

Poster Type: Clinical Practice Innovation

Description: In 2021, International Community Health Services (ICHS), an FQHC in King County, Washington, made a commitment to improve HIV screening and PrEP delivery among the diverse, multilingual communities served by the clinic. A multidisciplinary team was formed and has since evolved to become a formal HIV Prevention team consisting of providers, nurses, an HIV program director, and HIV patient educator. This poster will examine several innovative approaches the clinic has designed and implemented to make HIV prevention services more accessible, equitable, and culturally and linguistically appropriate. These strategies have included: electronic medical records enhancements, including implementation of a "care-gap" reminder for patients due for their HIV screening and nurse visits for STI screening and PrEP initiation. This allows patients who are at risk for HIV or express interest in PrEP to be quickly linked to care through our nursing team, who were trained to provide counseling about HIV risk reduction, perform a rapid HIV test, provide education about PrEP, and work with the patient's provider to offer same-day PrEP starts for at-risk patients. Patients also now have the option to see our nurses on a same-day or walk-in basis for STI testing instead of waiting for a later visit with their provider, which has facilitated another point of engagement for STI and HIV prevention. Pharmacy visits for PrEP initiation, similar to our nurse-led PrEP model, now provide patients who are at risk for HIV or express interest in PrEP with the option to be seen by a pharmacist at 2 of our clinic locations. This is an additional access point for our patients to initiate PrEP and allows them to be seen for a walk-in/same-day appointment. Workforce development regarding HIV prevention, includes a 7-week email series for providers, didactic sessions for providers and RNs, and training sessions for RNs.

Principal Findings: Several of our clinic's initiatives were launched in early 2023, so more data will be available by this summer when the poster presentation will be finalized. That said, across our 4 main clinical sites, we have already seen a 40 to 140% increase in monthly HIV testing and anticipate this trend will continue in the following months. The development of culturally sensitive and inclusive marketing materials and communications has allowed us to conduct outreach among communities who previously had access only to materials in English. Qualitative responses from providers, nurses, and clinical teams regarding our new pathways for PrEP initiation have indicated that these models are feasible, well received by staff and patients, and allow all members of the medical team to practice at the top of their scope. Preliminary data has also suggested that these initiatives have substantially decreased wait time for patients to initiate PrEP.

How this Project/Study Benefits Health Centers: This project benefits health centers who are looking to expand their HIV prevention services and address barriers such as patient access and language. In 2021, health centers had 2.7 million visits for HIV tests, a 34% increase since 2020. Yet despite expanded HIV prevention work within primary care, new HIV diagnoses continue to disproportionately affect people of color, immigrants, and the queer community. Community health centers play a vital role in HIV prevention and creating culturally inclusive media and clinical models is essential in increasing awareness and treatment for HIV, particularly among marginalized communities.

Learning Objectives:

- Identify new models for low-barrier PrEP access and HIV/STI screenings.

- Understand the role of a dedicated HIV prevention team and its benefits to better patient care.

- Describe the importance of culturally sensitive marketing material and provide examples of its application in HIV prevention and sexual health.

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Presenter(s): Antonio Foles, John Marrin, Omar Ramos

CP13

Using Data to Drive Clinical Quality Improvement Data

Poster Type: Clinical Practice Innovation

Description: HealthEfficient and the Qual IT Care Alliance HCCN is comprised of 50-member federally qualified health centers. The HCCN uses HIT to improve clinical and operational performance by leveraging digital health tools and dashboards to help member health centers identify opportunities for clinical quality improvement and promote health equity amongst members. Eight members of the Qual IT Care Alliance HCCN have participated in the Million Hearts Preventing Heart Attacks and Strokes (PHAS) Projects in Improving Statin Therapy and Improving Blood Pressure Control in African Americans since 2018. This poster will include data visualizations featuring the HCCN's data for hypertension control and statin therapy, comparing data from 2018-2021 (adding in 2022 when it becomes available) for health centers participating in both Million Hearts PHAS projects to the entire network. Data visualizations that will be included in the poster are: patients 18-84, with controlled hypertension (All HCCN member health centers) – 2018-2022; patients 18-84 with controlled hypertension (Million Hearts vs. Non-Million Hearts) – 2018-2022; Black and African American patients 18-84 with controlled hypertension (All HCCN member health centers) – 2018-2022; Black and African American patients 18-84 with controlled hypertension (Million Hearts vs. Non-Million Hearts) – 2018-2022; percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy (All HCCN member health centers) – 2019-2022; and percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy (Million Hearts vs. Non-Million Hearts) – 2019-2022. The poster will describe how the data are used with our peer learning groups to share effective strategies for improving blood pressure control and improve statin therapy, as well as to set network-wide goals for improvement.

Principal Findings: We observed slightly higher performance in both hypertension control and statin therapy of Million Hearts participants compared to Non-Million Hearts

participants between 2018-2022. In 2018, our Million Hearts Hypertension Control rate was 61%, and Non-Million Hearts was 58%; 2019 was 64% in Million Hearts and 61% Non-Million Hearts. In 2020, members experienced lower hypertension control rates due to COVID-19 with 57% in Million Hearts participants and 55% in Non-Million Hearts. Performance improved in 2021 with 59% in Million Hearts and 57% in Non-Million Hearts. We expect that 2022 results will similarly demonstrate continued higher performance in our Million Hearts participating health centers. As a network, hypertension control is a focus area for our HCCN. Our members tend to perform close to or above the national average for FQHCs on blood pressure control; continued emphasis and participation in the Million Hearts projects have consistently demonstrated higher rates in both measures.

How this Project/Study Benefits Health Centers: HealthEfficient and Qual IT Care Alliance HCCN use data dashboards to help identify and disseminate best practices for clinical quality improvement amongst our member health centers. By sharing data and improvement stories with each other, health centers learn how to avoid ineffective methods and leverage the most effective strategies to improve data and patient care.

Learning Objectives:

- Describe how the Qual IT HCCN uses innovative data integration to help promote clinical quality improvement in hypertension control and improving statin therapy.

- Contrast data from Million Hearts participating health centers to Non-Million Hearts participating health centers to demonstrate the network effect of focused interventions over time on improving an area of care.

- Reflect on the use of data dashboards to convey actionable data to community health centers for clinical quality improvement.

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Presenter(s): Michelle Tropper

Health Center Workforce Strategies

CP14

California's Central Valley Physician Shortage: An Inside Perspective

Poster Type: Health Center Workforce Strategies

Description: This project explores the physician shortage in California's Central Valley, an area responsible for a quarter of the nation's produce but challenged by a lack of access to healthcare providers. The project involved surveys of five physician networks and four medical student programs to identify factors that influence decisions to pursue physician

careers in the Central Valley. The top factor identified was a mission or desire to serve the underserved. Satisfaction with clinical training in the Central Valley was mostly related to relationships with colleagues and preceptors, but physicians ranked organizational leadership lowest and medical students ranked the quality of care patients receive lowest. The project recommends collaborations between medical schools and health centers to improve the quality of care that patients receive, and efforts to improve leadership structures and communication among physicians. The project also suggests encouraging a unified organization among undergraduate

students, medical students, residents, and physicians to foster positive relationships among colleagues and preceptors.

Principal Findings: Ninety-three physicians and thirty medical students participated in the surveys; 33% and 60% percent of the physicians and students were raised in the San Joaquin Valley (SJV), respectively. Both groups ranked mission or desire to serve the underserved as the top factor in deciding to practice/train in the SJV. Satisfaction of clinical training in the SJV were similar with most satisfying being relationships with colleagues/preceptors, but different in least satisfying with physicians ranking organizational leadership lowest and students ranking quality of care patients receive lowest.

How this Project/Study Benefits Health Centers: Collecting feedback from current physicians and medical students, health centers can identify areas of improvement and implement changes to create a more positive and fulfilling work environment. High levels of physician satisfaction can help reduce turnover rates and prevent the loss of experienced physicians. By regularly evaluating physician satisfaction, health centers can identify potential issues before they become major problems and take proactive steps to address them. Physician satisfaction and engagement are closely linked to the quality of patient care. Satisfied physicians are more likely to provide high-quality care and engage with their patients. By evaluating physician and medical student satisfaction, health centers can identify areas where improvements are needed to provide better patient care. Health centers that prioritize physician and medical student satisfaction are more likely to develop a positive reputation among healthcare professionals. This can lead to increased interest in working for the organization and improved recruitment efforts.

Learning Objectives:

▪ Assess the likelihood of medical students training in the San Joaquin Valley and their desire to work as a future physician in the San Joaquin Valley.

▪ Assess why physicians who are currently practicing in the San Joaquin Valley decided to work here and their level of satisfaction with their clinical practice.

▪ Establish a network among medical students, residents, and physicians in the Central Valley of California in order to encourage community engagement, unified scholarly activity, and to build a desire to serve the Central Valley.

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CP15

Diversity and Inclusion in FQHC Workforce: Importance of Investing in Staff Development for Equity

Poster Type: Health Center Workforce Strategies

Description: Federally Qualified Health Centers (FQHCs) are essential for providing healthcare services to underserved communities, and their success depends on staff engagement. This abstract seeks to highlight the importance of Diversity, Equity, Inclusion, and Belonging (DEIB) initiatives in FQHCs and their impact on staff recruitment, retention, wellness, inclusivity, and integration. The key to achieving DEIB initiatives is to ensure that executive staff is accountable and acts as allies in promoting a culture of inclusivity, which can lead to increased employee engagement, job satisfaction, and overall well-being. At Ryan Health, celebrating the diverse cultures and people (cultural identities of staff and patients) was prioritized. In addition, the establishment of employee community groups created safe spaces for staff of marginalized communities, leading to increased engagement and job satisfaction and better patient care outcomes. The continued dialogue was the key to embedding inclusion and belonging. Learning and development opportunities provided the perfect platform for ongoing conversations around difference and inclusion. Managers received training on crucial DEIB topics like psychological safety, unconscious bias, and cultural humility. This training provided them with the necessary knowledge and skills to create an inclusive work environment, promote staff inclusivity and integration, address issues of discrimination and bias, and provide the necessary support and resources for staff to thrive. In conclusion, implementing DEIB initiatives is vital to achieving staff wellness, engagement, and overall well-being in FQHCs. The commitment of executive staff to act as allies and promote inclusivity, the recognition of cultural diversity, and the provision of training on key DEIB topics are crucial steps toward building an inclusive and diverse workforce.

Principal Findings: Ryan Health's workforce dashboard revealed that 73% of their 531 employees were women, and 82% belonged to BIPOC groups. Senior management became more diverse, with the percentage of White employees falling from 65% in 2021 to 44.4% in 2022. The percentage of women in senior management increased to 46%, and BIPOC representation increased to 48% in management across clinic sites. Ryan Health staff created 5 Employee Community Groups (ECGs), and membership increased from 5 core members per ECG in 2021 to 8 in 2022 and 10 in 2023, with over 200 staff on the ECG membership listservs. In addition, in-person training led to a significant increase in manager attendance, rising from 85% to 97%, with an average satisfaction rating of 4.9 out of 5. These findings suggest that DEIB initiatives can lead to increased engagement, better recruitment and retention, and a more inclusive work environment. For example, after supervisors attended training on psychological safety, unconscious bias, and cultural humility, staff survey participation rose from 53 (10%) in 2021 to 238 (44%) in 2022.

How this Project/Study Benefits Health Centers: Having DEIB initiatives in an FQHC can help change the organization's culture by creating a more inclusive work environment where all employees feel valued, respected, and supported. This can increase employee engagement, job satisfaction, and overall well-being. DEIB programs can also help reduce incidents of discrimination, harassment, and bias, leading to better mental health and reduced staff stress. By utilizing training to advance the dialogue around DEIB topics, such as psychological safety, unconscious bias and cultural humility, managers can become more dynamic and culturally sensitive, creating an inclusive work environment. This can promote staff inclusivity and integration, address issues of discrimination and bias, and provide the necessary support and resources for staff to thrive. Creating safe spaces for staff of marginalized communities through employee community groups (ECGs) can create a sense of belonging and increase engagement and job satisfaction. When staff feels valued and supported, they are more likely to be invested in patient outcomes, leading to better patient care outcomes.

Learning Objectives:

- Understand the importance of leadership messaging and accountability in implementing DEIB initiatives in a clinical setting and how it can improve staff wellness, engagement, and overall well-being.

- Identify the benefits of increasing the recognition of cultural diversity in a clinical setting, such as the creation of safe spaces for staff of marginalized communities, which can lead to increased engagement, job satisfaction, and ultimately better patient outcomes.

- Explore how utilizing training to advance dialogue can be vital to implementing DEIB initiatives effectively by providing learning and development opportunities for managers on key DEIB topics such as psychological safety, unconscious bias, and cultural humility.

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Research

CP16

Improving Health Literacy in High School Students

Poster Type: Research

Description: Low health literacy can lead to undesirable health outcomes mainly due to a reduced understanding and management of one's treatment and diagnosis course. Improving the health literacy of young people, especially in the K-12 school system, not only influences their personal health behaviors, but also influences the health actions of their peers, families and communities to improve health status and reduce health disparities. The main goal of this project was to improve the health literacy of high school students in an urban school through education and research. To achieve this goal, students completed online health literacy modules to increase their knowledge on the importance of health literacy. It also taught them how to find credible online resources pertaining to health topics and how to navigate the healthcare system. Students also completed a health disparities project that consisted of them selecting a health disparity topic that affects their local community and doing a literature review to examine the biological, environmental, and lifestyle factors that lead to the disparity. They used data from the public browser of the All of Us Researcher Workbench to look at the prevalence of their disparity among marginalized populations. Finally, they completed a photovoice project to depict their research in pictures taken from their local community that was then used as a tool to engage the local community in discussions on the disparity and the All of Us research program. Students completed pre- and post-test health literacy assessment surveys to determine if engaging in these activities would increase their health literacy.

Principal Findings: Forty-four students completed the initial Health Literacy Assessment for Adolescents Survey. Preliminary findings showed that students on average had low health literacy in the communications domain, which demonstrates they have difficulties or discomfort asking their providers questions or obtaining and communicating health information. However, on average, students had high health literacy in the confusion and functional health literacy domain, meaning they have the ability to understand, read, and process health information. Correlational analysis revealed a significant correlation for individuals who had low health literacy scores for both communication and functional health literacy (coefficient = -0.32 (p 0.001). These findings suggest that individuals who have a decreased ability to understand and process health information also have a hard time communicating with their health providers.

How this Project/Study Benefits Health Centers: Improving health literacy is imperative to decrease the number of undesirable health outcomes, which lead to a lower quality of life. Educating young adults on the importance of reducing health disparities and raising awareness of programs like the All of Us research program allows them to become health advocates for people of all ages. Prior initiatives demonstrated that "youth whose lived experiences can be expressed in powerful ways" could bring forth a new generation of health messengers, to inspire their friends and family to understand the factors impacting their health and how to care for themselves. It also exposes students to community health centers as an access point for receiving care. Additionally,

exposing a diverse younger generation to the healthcare system, health disparities, and public health concerns may shift their career planning leading to a more diverse public health and community health center workforce.

Learning Objectives:

- Students are able to differentiate between credible and noncredible resources on the web to learn about important health topics.

- Students are able to identify and describe biological, environmental, and lifestyle factors that lead to health disparities.

- Students are able to better communicate, understand, and process health information in order to positively influence their own health behaviors.

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Presenter(s): Katrina Yamazaki, Amy Taylor

CP17

Building Research Capacity Within Federally Qualified Health Centers

Poster Type: Research

Description: The National Institutes of Health (NIH) All of Us Research Program (AoURP) aims to enroll and retain one million people across the US over ten years in a groundbreaking health database, empowering researchers to explore how biology, lifestyle, and environment impact health. The program focuses on enrolling participants historically underrepresented in biomedical research (UBR). To facilitate this priority, NIH partnered with MITRE to onboard eight FQHCs to recruit, enroll, and retain diverse participants. Since 2016, these FQHCs have elevated their research capacity, enrolling over 11,000 participants, employing over 70 full-time research staff, and publishing about their research programs. Over the six plus years of working to implement this monumental research program, MITRE and the FQHCs have learned the following key lessons:

- Because staff at FQHCs wear multiple hats, FQHCs must have the funding to dedicate staff to focus on research. Otherwise, staff are pulled in other directions. A program as complex and nuanced as the AoURP requires dedicated staff who have an in-depth understanding of the research program's Core Protocol and have had extensive training to execute enrollment.

- FQHCs must be empowered to lead within a large research consortium like AoURP. This can be challenging when FQHC teams are smaller than their more robust research medical center colleagues. The NIH AoURP recognizes FQHC leadership and value and prioritizes their voice within the AoURP consortium.

- Experts are required to help build research capacity. MITRE's contributions to laying the framework for FQHCs to build research capacity cannot be understated, while building the expertise among the FQHC staff will be a value-add to other research programs in the long run.

Principal Findings: Since 2016, the AoURP FQHCs have enrolled over 11,000 participants, more than 95% of whom are considered UBR. FQHCs' success as AoURP enrollment partners helps the AoURP database truly reflect the country's diversity. These efforts will contribute to research discoveries that benefit FQHC patients, their communities, and those underrepresented in research. FQHCs have the dedication, leadership, and wherewithal to operationalize a national longitudinal research study and will continue to be paramount for the AoURP reach its goal of 1 million, diverse participants.

- Building research capacity requires a weighty contribution from FQHCs (e.g., hiring and training staff, negotiating clinical space, obtaining funding, etc.).

- A successful research program includes providers, administrative staff, and ancillary departments who are supportive and who serve as research champions.

- Building research capacity requires project management. MITRE has developed and refined a set of tools and resources for FQHCs to successfully operationalize the AoURP.

How this Project/Study Benefits Health Centers: The innovations outlined identify not only the key success factors for new FQHCs to onboard and implement the AoURP as enrollment partners, but they can also be applied when introducing other research programs to FQHCs. These success factors can be replicated by using the framework developed by MITRE, by obtaining agreement from leadership to fulfill the key commitments identified above and by putting in place a team of people whose sole focus is on implementing and supporting research programs.The AoURP also exemplifies how FQHCs can be successful in operationalizing longitudinal research studies and innovating along the way. NIH recognized their value and aimed to maximize their success through support from MITRE. For FQHCs to build and sustain research capacity, they need to prioritize research at the leadership level, they need to seek funding opportunities within the research realm, and they need dedicated resources and staff to execute research programs.

Learning Objectives:

- Project management is required to develop research capacity and implement research programs. MITRE developed and executed the following resources to develop research capacity:
  - Implementation Roadmap - Outlines the five key phases: onboarding, strategic planning, acquisition, coordination, and activation, over a structured nine-month timeline.

- Electronic Health Record (EHR) Capability Assessment - Evaluates current state readiness for sharing participant EHR data with the AoURP, that focuses on EHR architecture, access to data, software, and hardware inventory, and EHR staff skills.
- Project Work Plan - Defines the FQHC's operational plans and timelines for reaching established engagement and enrollment targets.

- FQHCs must establish and maintain commitment to participate in research programs. MITRE identified three key commitment areas for FQHCs to successfully establish and maintain a research program:
  - Top-Down Support from the C-suite level of the FQHC is a critical success factor for implementing this research program; leadership support helps new initiatives integrate into the existing health centers.
  - Dedicated Focus on Research that separates clinic activities from research initiatives, allowing a research program to learn, grow, and test new opportunities.
  - Funding is crucial for health centers to build research capacity. Thus, FQHCs must actively explore and apply for research funding opportunities.

- FQHCs must hire staff who will be impactful in their unique roles and who will be empowered to lead within the larger AoURP Consortium.
  - A spectrum of dedicated staff from the MITRE and FQHC teams ensured success within the research program. MITRE experts in the areas of implementation, EHR / IT infrastructure, and project management developed the tools and processes FQHCs used as they grew their research capacity to become an AoURP enrollment partner. In addition, the FQHC leadership hired a principal investigator, a deputy principal investigator, a site manager, an EHR data specialist, and at least one research assistant prior to onboarding the FQHC to the research program. Having the staffing infrastructure in place early allowed the team to gain a strong understanding of the research program, develop into a cohesive team, and establish commitment early on.

- In addition, the AoURP consortium is composed of over 100 unique organizations, each of whom play a unique role in operationalizing the program and supporting its participants. FQHCs had a seat at the table within AoURP committees, boards, task forces, etc. Being an integral part of the governance of the research program ensured that FQHC voices were empowered to lead, make decisions, and shape the research program within their local communities.

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CP18

Let's Get REAL: Improving Race, Ethnicity, and Language Data Collection at Denver Health

Poster Type: Research

Description: Health outcome disparities related to racial and ethnic backgrounds are a pervasive and persistent concern in our health care system and the lack of high quality and accurate race, ethnicity, and language (REAL) data remains a challenge in advancing equity. Most recently, stark disparities in COVID-related outcomes were seen with a higher incidence of morbidity and mortality in the African American/Black and Hispanic populations. This pattern mirrors other health outcomes where people of color fare worse than their White counterparts. Despite the recognition of this difference in outcomes, our persistent failure to overcome such health disparities may be attributed to current race and ethnicity data collection practices that are non-standardized and lead to data that is either missing or highly variable in its reporting. As a safety-net institution, we serve a high number of patients that self-identify as Black, Indigenous, or People of Color (BIPOC). Despite having this diversity, our data showed that 15.5% percent of our patients did not have any race data, 9.1% did not have any ethnicity data, and 11.7% did not have any language data recorded.

Principal Findings: In 2021, we launched our race, ethnicity, and language (REAL) initiative. This project encompassed completing an environmental scan to understand the root causes in the missing information and development of a pilot program that focused on developing a culturally sensitive script, transcreation of the script in Spanish, and training for our staff on how to collect this information. With these findings we were able to build a more robust collection system in our EHR and rollout the training across our entire system. Missingness in our data decreased from >9% to 0.5% for both race and ethnicity information. Language missing data decreased from 12.7% to 4.0%.

How this Project/Study Benefits Health Centers: Community health centers are mandated to collect this patient demographic data. Most of the time, training regarding how to collect this sensitive data from patients is overseen and the quality of the data could be detrimental in efforts to improve the quality of care to minority populations. By developing a strategic program that focuses on improving data collection, clinics will be able to identify disparities in care more accurately. We cannot improve what we cannot measure (accurately!)

Learning Objectives:

- Understand the importance of improving Race, Ethnicity and Language (REAL) data collection to spearhead Diversity, Equality, and Inclusion (DEI) efforts.

- Improve your data collection scripting to be culturally sensitive and focused on your patient population.

- Implement a systematic training program where the end users not only learn the how, but the why collection of this data is critical for ongoing improvement projects.

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CP19

A First Look at All of Us Research Program Retention for Participants Without Housing or with Insecure Housing

Poster Type: Research

Description: The National Institutes of Health (NIH) All of Us Research Program (AoURP) aims to build a diverse health database of a million or more participants that reflects the diversity of the United States. Enrolling and retaining people who have experienced, or are experiencing, homelessness benefits the program by providing researchers access to data from participants whose lifestyle and environment are relatively understudied, and for whom many chronic conditions are more prevalent. Successful enrollment and retention in longitudinal studies like the AoURP will allow researchers to better understand determinants of health and outcomes for this understudied and vulnerable population, but retaining housing-insecure participants in a longitudinal study is known to be difficult.

Using data from the AoURP Data and Research Center, we set out to determine how housing stability affects enrollment and retention in the AoURP overall, and which organizations, if any, more successfully enroll and retain participants with insecure housing or who experience homelessness. We compared enrollment demographics and retention rates for participants who enrolled in the program through FQHCs with those who enrolled through regional medical centers (RMCs), which are typically large academic medical centers. We observed several differences between the two groups and began to determine possible explanations for those differences by conducting interviews with AoRUP representatives at FQHCs. Those interviews resulted in several reasonable hypotheses for the differences and generated additional research questions.

Principal Findings: Our data show that participants who enrolled in the program via FQHCs were more likely to have insecure housing or experience homelessness than participants who enrolled via RMCs. Additionally, program retention rates for participants with some manner of housing insecurity who

enrolled via FQHCs are at least 10% higher than for those who enrolled via RMCs. AoURP representatives at FQHCs noted that although they are often aware that an enrollee is experiencing homelessness, there are no differences in enrollment or retention processes for these individuals. Rather, FQHCs put forward several potential reasons for higher enrollment and retention rates. Foremost, the availability of other social services at FQHC sites (e.g., WIC) gives AoURP representatives more opportunities for contact with participants. Second, smaller, less intimidating facilities might foster stronger relationships. Finally, healthcare organizations that continue to provide care to patients who have lost insurance might also lead to more opportunities for contact.

How this Project/Study Benefits Health Centers: The results of this study benefit health centers in several ways. First, the results reinforce the value health centers provide to these underserved patients. As compared to RMCs, our data suggest that patients who are unhoused or have insecure housing are more likely to return to a health center for care. Second, these results arm health centers with proof-of-value to large-scale biomedical studies. Better retention for participants who have proven difficult to retain in prior research allows study directors to allocate resources more efficiently. Finally, developing a better understanding of why these study participants are more likely to stay involved in the AoURP will provide health centers with actionable recommendations that could also improve continuity of care for this vulnerable population.

Learning Objectives:

- Describe the demographic differences with respect to housing, between the AoURP participant populations at FQHCs and RMCs.

- Compare AoURP retention rates of patients who are unhoused or have insecure housing for participants at FQHCs and RMCs.

- Explain possible reasons for the differences in retention rates.

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CP20

The Way Forward Toward Health Equity in 2025

Poster Type: Research

Description: As health care systems begin to shift from paying health care providers for the volume of services offered to the value of what they do based on patient outcomes, there is an emerging and critical need to explore barriers that hinder access to care, build capacity to address the social determinants of health, and identify health equity building solutions to reduce the health disparities that impact communities. To address these emergent needs Health Center Partners of Southern California (HCP), a regional consortia of primary

healthcare organizations, launched a tri-phasic research initiative to learn directly from healthcare consumers at community health centers (FQHCs and Tribal health programs) and community-based organizations (CBO) about the conditions contributing to inequitable health care access and utilization in the communities that HCP and its members serve. Areas of inquiry across research strategies included barriers to care and utilization including insurance, provider/clinic communication, cultural competence, medical mistrust, and patient discrimination. The first two research phases initiated patient-facing data collection strategies for documenting the experiences, perceptions, and preferences of community health center consumers through intercept survey administration and focus group facilitation. A total of 307 consumer surveys were collected in English and Spanish from adult primary care patients at seven participating member health centers across San Diego County. Focus group participants (n=15) were recruited from surveyed patients to more deeply explore relevant survey topics and contextualize key findings. In parallel, key informant interviews with twelve community-based organization leaders were conducted to document local stakeholder perspectives on gaps and priorities for addressing health disparities and promoting health equity. Data collection activities and analyses concluded in January 2023. Aggregated summary reports were prepared and shared with member health centers and other key stakeholders. Importantly, findings from this research initiative will inform development of the HCP Center for Health Equity.

Principal Findings: Results from the HCP Consumer Survey and patient focus groups identified needs for improving provider communication skills; enhancing the system of identifying and responding to patient social risk; and addressing patients perceived inequities. For example, 43 of 264 patients surveyed (16%) said their health care provider frequently or sometimes didn't listen to what they had to say; 103 of 299 patients surveyed (34%) reported needing help accessing at least one social resource in the past year and 27 of those patients (26%) said their health center had helped them with access; and 12 of 297 patients (4%) felt they had been treated differently for one or more factors including their ability/disability, a health condition, type of insurance, or age. Conversely, 297 of patients surveyed (96%) felt they had been treated fairly and respectfully by clinic staff at their usual community health center regardless of race, sexual orientation, or gender identity.

How this Project/Study Benefits Health Centers: All 16 CEOs of HCP member health centers received an aggregated summary report of the survey results to identify shared challenges across FQHCs and Tribal health programs. CEOs of member health centers that participated in this research initiative (N=7) additionally received individualized survey results specific to their health centers to identify unique challenges and highlight what was working well. Key factors associated with patient retention and attrition were also indicated. Additionally, as a 2022 Taproot Foundation recipient, HCP also worked with Johnson & Johnson to develop a "Playbook" for benchmarking HCP's local consumer survey results against similar items on state and national surveys.

The Playbook was disseminated to member health centers along with the summary reports to enhance interpretation and utilization of the survey results. The Playbook also included "if-then" recommendations for next steps if specific results indicated areas for improvement.

Learning Objectives:

- Understand how to innovate and implement cost-effective and highly relevant research strategies for infusing the patient voice and community feedback into health equity building solutions for reducing health disparities and quality improvement.

- Identify and build new partnerships between community health centers and CBOs through key informant interviews.

- Provided staff with technical training on face-to-face interview administration and an opportunity to interact with diverse patient populations on-site at the member health centers they work to support.

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Presenter(s): Laura D. Stanley

CP21

A Data-Driven Approach to Understanding Factors Contributing to Health Inequities Among Community Health Center Patients

Poster Type: Research

Description: The poster will provide an overview of findings from Capital Link's updated 2017-2021 data-driven analysis on the factors influencing health inequities in FQHCs following its first Los Angeles-based study on the topic published in March 2022, A Data-Driven Approach to Understanding Factors Contributing to Health Inequities. The goal of this second study is to utilize the findings to make informed recommendations for how to best address and improve patient equity and inclusion efforts across health centers in Los Angeles County and the nation overall. For this follow-up analysis, Capital Link, again reviewed more than 100 factors for the 57 FQHC members of the Community Clinic Association of Los Angeles County (CCALAC) for 2017-2021. Like the prior study, the analysis considered population demographics such as health center patient service area social deprivation level, poverty, and homelessness, as well as racial and ethnic population composition, patient and payer insurance mix, service offerings, growth rates, and similar factors related to its long-term financial sustainability, accessibility, and health outcomes. In addition, for this latest analysis, we spoke with health center leaders and other industry stakeholders to better understand cultural, capacity, and other barriers to improving health equity. Results were reviewed from four perspectives as outlined below and reconfirmed important differences among FQHCs in Los Angeles County based on the characteristics

of the health centers and their patient populations. The findings are relevant for anyone working in community health settings with clients/patients coming from a wide range of backgrounds.

Principal Findings: The analysis documented the statistically weaker performance on financial strength, access to care, and/or health outcomes encountered by health centers with higher percentages of patients of color, with the notable exception of Asian patients in some instances. Health inequities were also evident in centers with a larger proportion of other vulnerable populations, including those with a high SDI. Since financially stronger health centers were shown to offer better access to care and higher quality outcomes, improving financial operations appears to be one important step toward reducing observed health disparities. With continued support from Cedars-Sinai, Capital Link will collaborate with CCALAC to build health center financial capacity in the region.

How this Project/Study Benefits Health Centers: As a critical component of the healthcare safety net, community health centers (CHCs) help ensure all patients have access to high-quality care regardless of ability to pay. However, barriers to care continue to disproportionally affect the most vulnerable patients, as we found in this study. Through our poster session we will provide data-driven conclusions and recommendations to assist health centers in improving access to care and clinical outcomes across health centers in Los Angeles County and the nation overall.

Learning Objectives:

- Understand the specific factors that most influence health equity in a nationally supported, community-based delivery system, based upon a data-driven analysis of patient populations and outcomes/access to care.

- Understand the relationship between financial stability of community providers and their ability to provide more effective and equitable care.

- Identify key strategies and action steps stakeholders can utilize to develop systems, strategies, and programs to lower barriers and improve access to high-quality care for all.

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CP22

Do You See Your Bias? Accent Perception in the Healthcare System

Poster Type: Research

Description: Accents are an important social stimulus that influence how we form groups and interact with others; it is a tool to judge or be judged, with significant social implications. Accent bias refers to the tendency for individuals to form judgments or make assumptions about someone based on

their accent or the way they speak. The listeners' bias impacts the speaker's lifestyle, affects their mental health, and subjects them to discrimination. In the healthcare setting, accent bias can lead to miscommunication, misunderstandings, and even misdiagnosis. Patients who are not understood properly may not receive the appropriate care, and this can have serious consequences for their health. Additionally, patients who feel judged or discriminated against based on their accent may be less likely to seek medical care, which can lead to further health complications. Understanding variables influencing accent perception is relevant to finding solutions for accent discrimination and listener bias. The purpose of our study was to identify stereotypical traits that influence accent perception. A total of 229 English native-speakers participated in the study. They completed a demographic and language background questionnaire, and listened to recordings from non-native English speakers reading sentences from the "Grasshopper Story" and rated their accentedness on a scale from 0-10. The experimental task presented the recording simultaneously with an image. The image could be an empty room, a picture of a person typically considered Latinx, or a person considered Caucasian based on physical features. Participants heard 15 accented voices randomly presented 3 times, and randomly matched with the 3 different pictures. Within-subject analyses were conducted comparing the individual responses to the 3 types of visual stimuli. Additionally, between-subject analyses were conducted to compare accent ratings between monolinguals vs. bilinguals, Midwest vs. California residents, and students of communication disorders vs. other majors.

Principal Findings: We found accent bias towards individuals with Latinx physical features. This bias is consistent across linguistic backgrounds, locations, or areas of study. Accent ratings were higher when audios were presented with pictures of a Latinx compared to audios presented with pictures of Caucasians or pictures of empty rooms. More accent was perceived when presenting photos of people vs. photos of empty classrooms, showing that the presence of a face has an effect on accent perception. No differences in accent ratings were found between monolinguals/bilinguals, or between Midwest/California residents. Accent bias was also found across areas of study. This is concerning in healthcare and specifically in communication disorders' students, who should be learning about the effects of accent bias and how to avoid it. They should be able to evaluate their own biases in order to grow their cultural competence and increase their clinical accuracy.

How this Project/Study Benefits Health Centers: Our results should inform healthcare professionals about unconscious accent bias and its negative consequences. This knowledge would help to better educate future healthcare professionals to recognize and work on eliminating their own accent bias. By being aware of accent bias and taking steps to minimize its effects, healthcare professionals can improve the quality of care they provide to their language minority patients. This may include actively listening to patients, asking clarifying questions, and being culturally responsive. Additionally, healthcare organizations can provide training and education to

their staff to help them better understand the impact of accent bias and how to address it in the workplace.

Learning Objectives:

- Explain why research on accent perception is important for healthcare professionals.

- Demonstrate the influence of visual stimuli on the perception of a foreign accent.

- Demonstrate that there is a listener bias that influences accent perception.

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CP23

The impact of FQHC Penetration on COVID-19 Mortality in Four United States Cities

Poster Type: Research

Description: The COVID-19 pandemic has had significant impacts on health care access and delivery, with disparate effects across social and racial lines causing health disparities to be exacerbated for the nation's most underserved communities. Emerging research suggests that inequitable access to health care in communities is the primary driver of COVID-19 outcomes, rather than underlying demographic differences in health status. While this evidence suggests that lack of access to timely or quality care is driving these prominent racial and socioeconomic COVID-19 disparities, to date, studies have not examined the role of FQHCs in this equation. Simultaneously, the COVID-19 pandemic disrupted health care delivery, particularly for the primary care system where chronic disease management and preventive care were delayed or foregone for long periods. FQHCs provide critical primary care services to the nation's most underserved populations, including many communities hardest hit by COVID-19. Throughout the pandemic, FQHC doors remained open and rapid transitions to telehealth occurred, ensuring care continuity for their patients. Thus, the contribution of the safety net to COVID-19 outcomes and recovery efforts has emerged as an important area of investigation. We conducted an ecological analysis to examine FQHC penetration, COVID-19 mortality, and sociodemographic factors in four major United States cities: New York, Chicago, Detroit, and Seattle. This poster will present the results from this analysis as well as programmatic and policy recommendations.

Principal Findings: COVID-19 mortality was significantly higher in communities with higher percentages of low-income residents and racial/ethnic minority residents. Higher FQHC penetration was associated with reduced COVID-19 mortality

rates across four major U.S. cities, highlighting the importance of the high-quality health care delivered by FQHCs and its protective role regarding COVID-19 among cities' most vulnerable communities. COVID-19 mortality rates were also positively associated with income and racial/ethnic minority groups, the primary populations served by FQHCs, highlighting the disproportionate disease burden in these communities. Our results support the emerging research showing that poor health care access is driving disparities in COVID-19 rates and outcomes to a greater degree than poor health status. Our study underpins the critical role of safety-net health care and policymakers must ensure investment in long-term sustainability of FQHCs through strategic deployment of capital, workforce development, and reimbursement reform.

How this Project/Study Benefits Health Centers: This study benefits health centers by providing new evidence of the protective impact FQHCs have on negative health outcomes, especially in low-income and underserved communities. By underscoring how FQHCs are a critical pillar of the safety net, this study highlights the need to support FQHCs to deliver necessary services to prevent widening disparities in health due to the COVID-19 pandemic. This new evidence can be used by health centers in efforts to advocate for increased investment to ensure their long-term sustainability.

Learning Objectives:

- Uderstand the impact of FQHCs in underserved communities during the COVID-19 pandemic in four US cities.

- Understand the disparate distribution of COVID-19 mortality within US cities and its association with community-level sociodemographic characteristics.

- Identify policy and programmatic recommendations to support the long-term sustainability of FQHCs.

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CP24

The Maternal Medical Home in FQHCs: Increasing Continuity of Care to Reduce Maternal and Infant Mortality Risk

Poster Type: Research

Description: Pregnancy-related deaths might occur up to a year postpartum. The maternal medical home (MMH) model, which coordinates perinatal care and integrates physical and behavioral health, shows promise in reducing maternal morbidities and closing equity gaps in birth outcomes (Howell et al., 2018). However, the utilization and benefit of MMH services remain unclear. With data from an FQHC, this study aimed to identify factors associated with perinatal care utilization among MMH patients. Deidentified data were pulled from the FQHC's electronic health records for 503 mothers with

singleton livebirth between July 1 to December 31, 2021. The research question is, among women who received prenatal care at the FQHC, who were more likely to have continuity of care? Continuity of care (COC) was operationalized as the mother had delivery service and at least one postpartum care provided by the OB-led team. Multivariable logistic regression was conducted in SPSS. We examined ten predictors including race/ethnicity, age, marital status, employment, insurance, pregnancy risk levels, total numbers of pregnancies, prenatal care utilization, and complications during childbirth. About one in three women identified as the Hispanic origin (n=177, 35%, including 166 White and 9 Black), followed by Non-Hispanic Black (n=156, 30.8%), Asian (n=95, 18.8%), Non-Hispanic White (n=76, 15%) and two American Indian and Alaska Native (0.4%). More than half were not employed (n=291, 57.5%), while 98 were working full-time jobs (n=98, 19.4%), 49 were working part-time (10.5%), and 28 were self-employed (5.5%). More than half (n=272, 53.8%) were married or had a partner, while 223 (44.1%) were single or divorced. Nearly half (42.7%) of the women were identified as having a high-risk pregnancy by their OB. Only 58.1% of women entered prenatal services during the first trimester, 33.2% during the second, and 8.5% during the third. About 48.2% were covered by Medicaid (n=246), followed by CHIP (81, 16.0%), Medicare (34, 6.7%), and marketplace insurance (31, 6.1%), and 70% on government-assisted insurance.

Principal Findings: Among women who had prenatal care at the FQHC, the majority of them were delivered by their provider (n=381, 75%), and 58.5% (n=295) had continuity of care with them. The final model was significant (X^2=149.298, df=19, p.001), and had more prenatal visits (Exp(B)=1.307, p<.001). Those who were less likely to have COC were covered by government-sponsored insurance (Medicare, Exp(B)=.370, p=.013, compared to private insurance) and had more pregnancies (Exp(B)=.776, p=.001).

How this Project/Study Benefits Health Centers: By identifying predictors of continuity of care (COC) and factors that hinder or promote perinatal care utilization, this study can help health centers improve their services and care models to serve perinatal patients better. Specifically, health centers can use these findings to target resources and interventions to high-risk patients, such as older mothers or those with pregnancy complications, to improve COC and perinatal outcomes. Furthermore, understanding the impact of insurance coverage on COC can help health centers design programs and policies that maximize coverage and minimize barriers to care for perinatal patients. Ultimately, this study can help health centers achieve their goal of improving the efficiency of their operations and providing innovative patient care solutions.

Learning Objectives:

▪ Identify factors associated with perinatal care utilization among maternal medical home patients.

▪ Evaluate the utilization of maternal health services among patients in an FQHC.

▪ Analyze the impact of maternal age, prenatal care utilization, pregnancy complications, and insurance coverage on continuity of care for perinatal patients.

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Presenter(s): McClain Sampson

CP25

Provider Perceptions of Clinical Pharmacy Services at Federally Qualified Health Centers in Ohio

Poster Type: Research

Description: Federally Qualified Health Centers (FQHCs) experience significant employee turnover resulting in decreased productivity, increased workload, and stress for remaining employees in an already resource-scarce setting. One factor of interest that impacts job engagement and well-being is interprofessional teamwork. Specifically, it has been demonstrated that clinical pharmacy services (CPS) positively affect providers' work-life; however, no studies have explored this relationship in FQHCs. This study assessed providers' satisfaction with CPS, perceptions of the impact of CPS on patient care and provider well-being, and the potential impact of CPS on provider retention. In the Fall of 2022, an anonymous survey was distributed, via QualtricsTM, to non-pharmacist providers practicing at Ohio-based FQHCs with access to CPS. The survey consisted of 21 Likert scale, multiple choice, and free-response questions. Some survey questions were developed using published surveys as a template and others were created de novo based on pertinent factors within the current literature.

Principal Findings: The survey was distributed to 205 providers, of which 50 responded (24% response rate). Over 82% of respondents were extremely satisfied with CPS. In perceptions of patient care, providers strongly agreed (86%) that removing or limiting access to CPS would negatively impact the quality of care to their patients. Providers noted that CPS positively impacted their well-being, specifically; contributing to a more manageable workload, increased professional development and continued learning, and allowing providers to focus on more professionally fulfilling tasks (r= 0.86; p<0.001). CPS positively impacted (83%) providers' likelihood of staying in their current position at their organization.

How this Project/Study Benefits Health Centers: With the degree of provider burnout in primary care, this study provides additional insight into providers' perceptions of the effect of interprofessional teamwork between primary care providers (PCPs) and pharmacists in FQHCs. The results highlight PCPs' positive perceptions of the impact of CPS on patient outcomes, elements of provider well-being, and provider retention. These

results should be utilized by FQHC leadership to understand the contributions of CPS to patient care and provider well-being and retention, which support the expansion of CPS at FQHCs.

Learning Objectives:

- Define the quintuple aim of healthcare.

- Review the current state of clinician burnout in primary care.

- Discuss the impact of clinical pharmacy services on provider satisfaction, well-being, retention, and patient care.

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CP26

Addressing Food Insecurity by Increasing Knowledge of Local Food Pantries at NYU Langone Family Health Centers

Poster Type: Research

Description: Food insecurity has been identified as a significant risk factor for many chronic diseases such as hypertension, diabetes, and obesity, all of which are highly prevalent within the Sunset Park patient population. As food insecurity persists in Sunset Park, many residents are at higher risk for acute or chronic diseases. It has been determined that food pantries have been instrumental at addressing food insecurity in other communities. The purpose of our quality improvement project was to increase awareness of food insecurity in Sunset Park and local food pantries amongst the NYU Langone Family Health Center (FHC) healthcare and medical staff. Through providing education regarding available resources, we aimed to increase staff willingness to assess food insecurity within the clinic and for them to initiate conversations with patients. The participants of our study included the medical staff within the NYU Langone FHCs. We conducted this quality improvement project by administering a pre-assessment survey to evaluate current screening habits, knowledge of local pantries, and if the staff has referred patients to the Table, a local food pantry affiliated

with NYU Langone Health. We then delivered an educational presentation regarding food insecurity, its relevance to chronic disease, and local food pantry resources. After the presentation, we provided a post-assessment survey so the medical staff could rate their perceived knowledge about the Table and local pantries and whether they believed they would be more or less likely to have conversations about food insecurity with their patients in the future. The data collected was both quantitative categorical data and qualitative data. We analyzed the data using descriptive statistics and a two-sample t-test. The project was well supported by clinical leadership within the NYU Langone FHC health system.

Principal Findings: Our study included 81 individuals across 7 FHC sites. Based on our pre-assessment survey, 48% of these individuals had never previously addressed food insecurity with patients in the clinic. Prior to the presentation, 10% of individuals expressed hesitation regarding referring patients to a food pantry. After the presentation, 100% of individuals reported they are more willing to assess patients for food insecurity going forward, and 100% of individuals reported willingness to refer patients to food pantries like the Table after listening to the presentation; however, 4% still noted some hesitation. Addressing these hesitations through offering more information about the Table and the referral process can be explored in the future. Initially, only 16% of participants stated that they knew enough about the Table to refer patients, which increased to 49% of participants after our presentation. Thus, individuals showed a significant change in awareness levels after the intervention.

How this Project/Study Benefits Health Centers: Providers within the CHC system are overwhelmed with a large volume of patients with chronic diseases; it can be difficult to manage particularly in a patient population with financial barriers. Studies have shown that food insecurity is prevalent within Sunset Park and that it is linked to chronic disease. Therefore, by providing resources and increasing awareness of food pantries, we hope that individuals in need can receive access to healthy foods and ultimately have decreased prevalence and incidence of chronic disease. This can be replicated at other sites through food insecurity education and also by implementing tools within the electronic health record to easily refer patients to food pantries.

Learning Objectives:

- How does this project benefit health centers?

- Can healthcare providers be convinced of the role food pantries can play in chronic disease management?

- What is the best way to deliver this information to healthcare providers?

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Presenter(s): Reilly Edmonds, Mariam Girgis

CP27

Evaluating the Impact of a Digital Health Promotion Intervention on Outpatient Substance Use Disorder Treatment Engagement

Poster Type: Research

Description: Community health centers are increasingly providing outpatient substance use disorder treatment, yet sustaining patient adherence and engagement continues to be a challenge. The purpose of the study was to determine whether a digital platform that combines daily educational/motivational text messages and the use of Contingency Management – whereby patients earn points for treatment attendance and engagement behaviors that can be redeemed for rewards – was an acceptable and impactful intervention. Method: Following IRB approval, 10 established patients (>/= 18 years old, English or Spanish speaking), recruited from a substance use disorder intensive outpatient program in Connecticut, consented to participate in a 4-week pilot trial of a novel digital health promotion intervention that was created via funding by the NIH's Small Business Innovation Research Program. Participants received daily motivational text messages and had the opportunity to earn up to 6,090 points (redeemable for up to $40 on a Visa debit card) by completing certain healthy behaviors, such as attending group treatment sessions, refraining from cell phone use during sessions, and minimizing breaks during sessions. Participants' rate of engagement with reward-eligible health behaviors were compared to the baseline rates provided by the clinic.

Principal Findings: On average, group therapy session attendance increased by 17% (88% vs. a 75% pre-intervention rate). There was a 14% improvement in participants staying for the duration of group sessions (97% vs. 85% pre-intervention rate). Refraining from cell phone use increased 72% (86% vs. 50% pre-intervention), and refraining from taking excessive breaks during sessions increased by 23% (92% vs. 75% pre-intervention). Participants earned a mean of 3,650 points (59% of total eligible points), and the average total cost of incentives

was $36.20 per participant. The program's assistan director noted that "a lot of [the patients] are really saying great things about the inspiration texts," and participants reported that intervention was "a great motivator," "easy and helpful," and "that the point system just assures you that [you're] doing good." This pilot demonstrated that, with an effective planning process and relevant resources, a messaging and Contingency Management-based health promotion intervention can be implemented at a very modest cost and achieve measurable improvements in patient behaviors within a relatively short period. The Aqueduct platform seems promising for improving sustained substance use treatment engagement in community-based settings.

How this Project/Study Benefits Health Centers: Community health centers are increasingly providing outpatient substance use disorder treatment, yet sustaining patient adherence and engagement continues to be a challenge. The pilot study presented here demonstrates the potential for a NIH-funded digital health platform to improve patient engagement in treatment at a modest cost within a relatively short period of time.

Learning Objectives:

- Describe patient engagement challenges during outpatient substance use disorder treatment.

- Evaluate the impact of a digital health promotion intervention on patient engagement in outpatient substance use disorder treatment.

- Discuss the potential use of a multifaceted digital health promotion intervention in outpatient community healthcare settings.

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Presenter(s): Aviva Ariel-Donges, William Tan

CP28

Critical Analysis of Transition Services Program for Management of Opioid Use Disorder and Its Future Improvements in Multnomah County

Poster Type: Research

Description: The US is currently enduring its fourth wave of the overdose crisis. In the past ten years, there have been substantial increase in overdose deaths, with formerly incarcerated individuals being nearly 40 times more likely to die of an overdose than the general population. The purpose of this project was to identify gaps in care continuity for populations with Substance Use Disorders (SUD) being released from the Multnomah County Corrections Health (MCCH). This project was an observational study focused on individuals who were released from corrections with a care plan in place prior to discharge. Qualitative data were utilized

through meetings with the Transition Services Program (TSP) to establish long-term solutions for gaps in care continuity for individuals released from jail. The first step in our project was meeting with the TSP team to develop a needs assessment based on their observations of successes and shortcomings within their program. In developing our needs assessment, we analyzed the roles of TSP employees, healthcare services provided to clients, and available community resources for SUD upon release. Our second step was to tour the Multnomah County Jail facilities to observe medical providers in the clinic. The goal was to build upon our needs assessment by understanding the operations of the jail's health services and the challenges clients face in addressing their healthcare needs after their release. In tandem with this assessment, we conducted a survey of the existing community healthcare services to observe clients' options for SUD. Lastly, our third step was to shadow members of the TSP team when they interviewed clients and administer surveys to the clients regarding their encounters with TSP. Our goal was to collect data directly from the clients regarding their experiences and hardships and present these findings to the TSP team.

Principal Findings: The qualitative analysis from our observational study within MCCH helped expose the need for increased wrap-around services for the population immediately leaving the jail system. Our report analyzed gaps in staffing, community collaboration, and insufficient support to the healthcare needs of this population. Our findings illustrate that the TSP team is appropriately positioned as the first point of contact to address the gaps in providing care coordination and healthcare for clients with SUD. However, the novelty of their program, their insufficient support, and recognition by community healthcare providers limit their ability to provide necessary and lifesaving services to the population impacted by the legal system. We recommend a two-fold approach. Our assessment found clinics and providers in place that provide low-barrier treatment for Opiod Use Disorder (OUD). However, there lacks a clear and concise bridge. Thus, we find it crucial to support TSP while simultaneously enhancing the existing community services.

How this Project/Study Benefits Health Centers: To support this work, it would be wise to model other successful outreach programs currently operating in Multnomah County. A similar approach should be designed across all community CHCs and develop a partnership with local correctional facilities. This gap is present at every segment of the healthcare system and scaling this model toward all CHC's is imperative. The approach can include conducting a needs assessment and observing a baseline understanding of the current transitional healthcare services. We consider it important to amplify the work from existing outreach programs that provide exemplary models that can be used as guideposts towards implementing proven methods of engagement. Bolstering the current healthcare services to meet the needs of people leaving the correctional system is vital toward reducing preventable deaths.

Learning Objectives:

- Understand the experiences and challenges faced by clients with OUD that are transitioning from jail to the community with support from the Transition Services Program (TSP).

- Recognize some of the barriers TSP encounters that hinder clients' successful transition.

- Identify potential solutions to address the lack of support and resources for the TSP, and develop recommendations to improve accessibility of care for clients.

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Presenter(s): Camille Johansen, Nena Nakum

CP29

The Impact of the Pandemic on Federally Qualified Health Center Patients with Type II Diabetes: A Case Study

Poster Type: Research

Description: Studies have shown that interruptions in care due to natural disasters may be associated with an increase in the rate of uncontrolled chronic diseases. In 2020, the COVID-19 pandemic served as a unique catalyst for interruptions in access to health care. This poster will illustrate trends in service utilization and short-term, diabetes-related outcomes among a cohort of type II diabetes patients at a federally qualified health center (FQHC) network in New York City during the early months of the pandemic. This research was conducted through an analysis of electronic health records from Urban Health Plan (UHP), an organization of twelve FQHCs in the Bronx, Queens, and Central Harlem. A cohort of 8,126 patients with a diabetes diagnosis were the focus of these analyses and represent all data points discussed. This case study will describe the changes in patient volume, visits, and the shift in visit types, in addition to the changes in characteristics of the populations that used specific services. Figures will include service area maps, trendlines to illustrate changes in patient volume and services, and stacked bar graphs/pie charts to communicate the characteristics of this cohort at different stages. By examining service utilization and trends during this unprecedented period, this case study demonstrates the resilience of UHP and underscores the importance of health centers to communities.

Principal Findings: After the onset of the COVID-19 pandemic in New York, UHP experienced a period of reduced patient volume. A 15.6% drop in visits and an 83.1% drop in A1c tests were observed between February and March 2020. During this initial period of reduced patient volume, the uninsured population made up a larger proportion of A1c testing as compared to previous months. Uninsured patients made up 13% of A1c testing in February 2020; by April 2020, they made up 27%. The average A1c value among tested patients increased during this time. Enabling services experienced shifts in April 2020. Visits with a nutritionist dropped 97% between March and April. Visits with social workers increased during this time. Telehealth helped keep patients engaged. In April 2020, 89% of visits were via telehealth, compared to zero telehealth visits in February. Despite these challenges, UHP returned to near-normal patient volumes by the summer of 2020.

How this Project/Study Benefits Health Centers: Interruptions to care due to natural disasters and public health emergencies remain a threat to the health care system. This case study adds to an existing pool of literature surrounding operations and outcomes at FQHCs during the COVID-19 pandemic. By sharing the trends in service utilization and short-term, diabetes-related outcomes, health centers can better recognize how these interruptions impact their patients. Additionally, by highlighting the shift in patient characteristics over different periods of time, this research underscores that health centers are crucial to individuals who are uninsured. These findings also lend themselves to policy recommendations that can better support health centers and will be included in this poster. Specifically, how current fee schedules impact how patients with different payer types can receive services. Finally, by sharing this story from UHP, other health centers can identify solutions and other adaptations to best serve their populations in the event of future interruptions.

Learning Objectives:

- Understand shifts that can occur within the operations of a health center during times of extreme disruption.

- Identify how interruptions to health care access can impact patients with type II diabetes.

- Apply shared interventions to best fit your practice in the event of future interruptions to care, such as natural disasters or public health emergencies.

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Presenter(s): Alexis Simonetti

CP30
Asian Americans' Approach to Behavioral Health

Poster Type: Research

Description: The poster will present findings of a wide community-based research, conducted in Houston MSA, targeting Asian/Asian Americans to find out the barriers and stigmas for behavioral health and behavioral services in this community. There were 2700 surveys and 8 focus groups conducted over 3 years in Asian majority ethnicities: Vietnamese, Chinese, Indian, Pakistani, Arab, Persian, and Filipino. The results show consistent behavior trends in this diverse group and also identified causes for lack of seeking behavioral health services.

Principal Findings: Behavioral health is the least important topic under discussion in Asian households. Most Asian languages like Vietnamese and Urdu do not have exact translations for common behavioral conditions like depression and anxiety, hence those populations cannot identify the symptoms as a health condition but rather deal with them as behavioral or religious issues. There is wide understanding of a communication gap in the mutigenerational Asian household that results in hindering the American born generation to seek help also.

How this Project/Study Benefits Health Centers: The study dismantles the popular image of Asian communities as "the model minority" and presents evidence that the community is as vulnerable as others when it comes to behavioral health services. Based on the findings, health centers providing holistic care (physical and behavioral) would be able to provide equitable and culturally appropriate care to Asian clients, hence identifying causes for their vulnerability for behavioral health issues.

Learning Objectives:

- Raise awareness in all sub-ethnic Asian communities through trusted means that will take consideration of the cultural values of each sub-community.

- Increase the number of culturally and linguistically competent behavioral health providers.

- Understand the use of disaggregated for allocation of resources to the Asian communities.

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Presenter(s): Anila Khan

CP31

Using Data Visualization to Assess Maternal Health Care Delivered at Federally Qualified Health Centers - United States, 2021

Poster Type: Research

Description: Federally Qualified Health Centers (FQHCs) are a critical source of maternal health care for women in the United States. From 2017 to 2021, over 500,000 patients per year sought prenatal care at FQHCs, and nearly 1.8 million visits to FQHCs in 2020 were pregnancy-related. To date, the National Ambulatory Medical Care Survey Health Center Component (NAMCS HCC) is the only source of nationally representative data on care provided at FQHCs. For the 2021 survey year, the National Center for Health Statistics (NCHS) transitioned the NAMCS HCC from manual medical record abstraction to electronic health record data transfer. With this change, the 2021 NAMCS HCC is comprised of data from more than 3 million visits at participating FQHCs.

Principal Findings: Using data from the 2021 NAMCS HCC, NCHS will develop a data visualization that allows users to view nationally representative estimates of counts and rates of maternal health care visits at FQHCs, stratified by selected patient demographics. Measures of maternal health care will include both prenatal care visits and postpartum care visits as defined by relevant diagnosis codes, and demographics will include categories for patient age and patient race and Hispanic ethnicity. Estimates are not included in this abstract because weighting of EHR records in the 2021 NAMCS HCC is not yet complete.

How this Project/Study Benefits Health Centers: This project will describe the methods and development of a data visualization using EHR data from the 2021 NAMCS HCC, which provides nationally representative estimates of counts and rates of maternal health visits at FQHCs and will be updated as subsequent years of data become available.

Learning Objectives:

- Describe EHR data collected in the 2021 NAMCS HCC.

- Discuss key findings related to maternal health care at FQHCs using the 2021 NAMCS HCC.

- Locate where publicly available data on health centers resides on the NCHS website for further assessment of this and other topics.

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Presenter(s): Zachary Peters, Jill, Ashman, Joy Ukaigwe

CP32

Estimates of Visits for Mental Health and Substance Use Disorders at Federally Qualified Health Centers - United States, 2021

Poster Type: Research

Description: According to the Health Resources and Services Administration (HRSA), nearly all Federally Qualified Health Centers (FQHCS) provide mental health care. Further, HRSA notes the importance of providing care related to mental health and substance use disorders amid emerging public health threats, such as the COVID-19 pandemic. However, nationally representative estimates detailing care delivered at FQHCs for mental health disorders among specific patient populations have yet to be produced using data collected during the COVID-19 pandemic. To date, the National Ambulatory Medical Care Survey Health Center Component (NAMCS HCC) is the only source of nationally representative data on care provided at FQHCs. For the 2021 survey year, the National Center for Health Statistics (NCHS) transitioned the NAMCS HCC from manual medical record abstraction to electronic health record (EHR) data transfer. With this change, the 2021 NAMCS HCC is comprised of data from more than 3 million visits at participating FQHCs.

Principal Findings: Using data from the 2021 NAMCS HCC, this research will assess nationally representative estimates of counts and rates of visits at FQHCs related to mental health and substance use disorders, including opioid use disorders; estimates will be stratified by selected patient demographics, including patient age and patient race and Hispanic ethnicity. Visits for conditions of interest will be defined according to diagnoses coded in EHR records in the 2021 NAMCS HCC. Visit rates will be calculated using estimates of the US civilian non-institutionalized population produced by the US Census Bureau, Population Division. Estimates are not included in this abstract because weighting of EHR records in the 2021 NAMCS HCC is not yet complete.

How this Project/Study Benefits Health Centers: This poster will highlight key findings related to mental health and substance use disorder care at FQHCs and will describe future research opportunities using the 2021 NAMCS HCC data to assess mental health care at FQHCs.

Learning Objectives:

- Describe EHR data collected in the 2021 NAMCS HCC.

- Discuss key findings related to care for mental health and substance use disorders at FQHCs using the 2021 NAMCS HCC.

- Locate where publicly available data on health centers resides on the NCHS website for further assessment of this and other topics.

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CP33

The Association of ACE Scores and Chronic Health Outcomes Among Patients with Chronic Pain Using Behavioral Health Interventions

Poster Type: Research

Description: The purpose of this project is to evaluate changes in the PROMIS-21 pain score pre- and post-behavioral health (BH) intervention for patients with chronic pain and Adverse Childhood Events (ACE), who are enrolled in the Buena Vida Pain Program at El Rio Community Health Center. This is a retrospective cohort study to quantify the efficacy of behavioral health, in chronic pain management in patients that have experienced ACEs. The goal of this project is to utilize ACE scores to inform providers to tailor treatment plans in other pain programs. Data analysis was completed on EHR data from El Rio Community Health Center. We applied inclusion and exclusion criteria to the population of Buena Vida Pain Program patients to establish a study population. We then completed a paired t-test on the entire cohort to determine whether or not there was a change in the mean pain levels experienced, mean blood pressure, mean BMI, and mean hbA1C before and after a behavioral health intervention. Then, we stratified the study population into groups with an ACE score of 0, ACE score of 1-3 (intermediate risk), and ACE score of 4+ (high risk). Among the strata, a t-test for pre- and post-BH intervention pain levels was completed.

Principal Findings: Our study tested a sample size from a population that is enrolled in the Buena Vida Pain Program at El Rio Community Health Center. All participants were offered access to BH services. The cohort includes those who completed at least one session of behavioral health. Data analysis is ongoing. Our hypothesis is that there will be a statistically significant decrease in PROMIS-21 score within the cohort between pre- and post-BH intervention. Additionally, we will assess pre- and post-BH intervention PROMIS-21 scores across each ACE score strata. This will be represented by a p-value from a paired t-test. We also hypothesize there to be a change among blood pressure, BMI, and hbA1C pre- and post-BH intervention. This will be demonstrated via a paired t-test. All analysis will take place in the statistical software RStudio.

How this Project/Study Benefits Health Centers: We will provide evidence in support of the Buena Vida Pain Program's approach to treating patients with chronic pain. This can aid in future endeavors such as applying to grant funding for Buena Vida and El Rio Community Health Center. Additionally, study findings can encourage the use of behavioral health interventions in treating patients with chronic pain and ACE

at other health centers. Finally, this project can inform other physicians and health centers on the importance of ACE screening for an informed-approach to treating their patients that experience chronic pain.

Learning Objectives:

- Understand that utilizing behavioral health as an intervention in treating patients with chronic pain and ACEs affects their pain level.

- Describe how patients with chronic pain and ACEs, who utilize a behavioral health intervention, can see a change in their markers of chronic disease, including hbA1C, blood pressure, and BMI.

- Understand that ACE scores can affect chronic pain levels, thus ACE screenings can help inform and tailor treatment for patients with chronic pain.

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CP34

Stress and Resiliency Strategies Among Health Professions Students

Poster Type: Research

Description: Human physiology has adapted to stress by striking an equilibrium with environmental changes that occur constantly around us. Excess stress imposes negative consequences on our bodies, which can have a negative impact on health professionals' education and careers (Gibbons, Dempster, Mountray, 2008). The purpose of this study was to assess stress levels and current coping mechanisms among health professional students in a rural Ohio community and to propose new stress intervention strategies. More than one-hundred nursing students enrolled at Southern State Community College (SSCC), attending either the Hillsboro or Mt. Orab campus, were offered participation in a wellness event. This event involved discussion regarding the impacts of stress on health and different stress mitigation techniques. At the event, the students were given anonymous pre-surveys assessing their current causes of stress and their coping strategies. A one-hour informational session was then conducted. During this session, students were taught about hormones, diet, exercise, and sleep and their corresponding relationships with stress. The session also highlighted various coping strategies and mindfulness activities including progressive muscle relaxation, 4-7-8 breathing (a form of deep breathing), yoga, body scanning, and meditation. Each student had an opportunity to practice the aforementioned techniques. After the session, the students were

invited to complete a post-survey, assessing the likelihood of utilizing these coping strategies/mindfulness activities and to what extent the educational session was considered beneficial.

Principal Findings: There were 29 nursing students who chose to participate in the survey and wellness session; 26 students (89.7%) felt their stress was caused by academic/career expectations and examinations/graded activities; and 17 students (58.6%) perceived increased stress due to financial burdens. Performing calming activities, seeking support, and conversing with family or friends outside of school were the most reported stress reduction strategies utilized by the students. Body scans, progressive muscle relaxation, and meditation were the least utilized strategies. There were 24 students who completed the post-survey and consider the stress coping strategies discussed and demonstrated as beneficial and likely to be used (P = 0.00000003). Furthermore, 17 students (75%) felt deep breathing techniques such as 4-7-8 breathing, scoring a 5/5 on the post-survey, were the most helpful and most likely to be utilized in the future.

How this Project/Study Benefits Health Centers: Focusing on the mission of community health centers to improve health and wellness, this project was designed to identify a group of rural individuals from communities served by our local FQHC, HealthSource of Ohio. In doing so, we chose to work with health professions students located in a rural Ohio community who may be dealing with increased stress, not just from school, but also due to financial and other struggles. We provided education on stress-reduction strategies which could help navigate daily stressors and improve lifestyle outcomes. Community health centers could adopt this initiative by determining the stress level of their healthcare professionals, students, and patients and then analyzing the impact stress-reduction techniques and mindfulness activities have on these individuals. Plans to implement a similar program at our local community health center, HealthSource of Ohio, are currently being considered.

Learning Objectives:

- Identify a community of individuals in need and evaluate the levels of stress and current, identified stressors among these individuals (rural health professions students).

- Analyze the stress reduction methods and mindfulness activities currently used by these rural health professions students.

- Provide education on new ways to mitigate stress and increase resiliency, which could have an impact on rural health professions students and the greater community.

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CP35

Differences in Documenting Social Drivers of Health in Electronic Health Records

Poster Type: Research

Description: As part of the Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity 2022-2032, CMS designated the expanded collection, reporting, and analysis of standardized data of SDoH as one of five priority areas. To encourage this collection and reporting, CMS is adopting two measures for voluntary reporting in calendar year (CY) 2023 and mandatory reporting beginning in CY 2024 to determine payment for fiscal year 2026. Of the two measures, Screening for Social Drivers of Health measure is intended to capture whether a healthcare organization is screening for patients' health-related social needs in five domains: food insecurity, housing instability, transportation needs, utility difficulty, and interpersonal safety.The lack of standardization in the collection and documentation of this data poses challenges for health systems. This poster will highlight differences in the collection and recording of SDoH terms within two similar EHR systems. We will also introduce a simple NLP process that could be utilized to extract relevant text from clinical notes.

Principal Findings: Efforts to document food insecurity, housing instability, and transportation needs vary by clinic and provider based on the surrounding demographics the clinic is located in, the workflow within a clinic, and utilization of SDoH questionnaires. Lexical variants in clinical notes result in suboptimal transfer of SDoH to ICD codes. Simple NLP processes may be applied to extract relevant text that may be missed by the coding process.

How this Project/Study Benefits Health Centers: As a health system whose mission is to provide "coordinated, culturally and linguistically competent, and community-directed" care, CHCs provide enabling services to address their patient's social needs. Knowledge and awareness of how SDoH are documented in the EHR is important to the mission of providing care and to direct appropriate enabling services for patient care.

Learning Objectives:

- Assess the differences in EHR documentation for homelessness, food insecurity, and transportation challenges.

- Compare occurrences in clinical notes for homelessness, food insecurity, and transportation challenges.

- Examine opportunities to address CMS's SDoH quality measures for health equity.

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CP36

Understanding Clinician Engagement in the Patient Scheduling Process

Poster Type: Research

Description: Some clinicians are known to schedule follow-up appointments for their patients, even though they are not expected to engage in this administrative process. There is limited research that describes why clinicians might actively engage in patient scheduling. A better understanding of clinician motivations for engaging in patient scheduling, despite the perceived increase in administrative burden that comes along with the process, may provide insight into its impact. The purpose of this project was to explore experiences with a clinician-led, patient scheduling process at a federally qualified health center. At an urban community health center, a cohort of primary care clinicians were given the option to engage in the process of scheduling their own patients. To better understand their experiences with this process, the clinicians were asked to complete a brief, anonymous survey via email related to this clinician-led, patient scheduling process. The survey included questions that elicited the clinician's perspective on how clinician-led scheduling could increase awareness of factors that may impact the patient's ability to schedule appointments, quality of care, patient-clinician relationships, and clinician autonomy.

Principal Findings: The majority of the survey respondents reported that they believed clinician-led, patient scheduling increased their awareness of factors impacting the patient's ability to make appointments and it was helpful to their practice. Most respondents reported that they believed clinician-led scheduling positively influenced the quality of patient care. The most common factors that influenced clinicians' decisions to engage in the scheduling process were the acuity and the complexity of the patient's condition. Most respondents felt that the efficiency of clinic schedulers also influenced their decision to schedule patients. The survey respondents were divided in regards to whether clinician-led, patient scheduling provided enough value to be worth the administrative burden. More research is needed to fully understand the impact of clinician-led scheduling on continuity

of care, quality of care, and to identify ways to optimize this practice for clinicians who seek to engage in the process.

How this Project/Study Benefits Health Centers: Clinician-led, patient scheduling is a process that has the potential to positively impact patient outcomes. This project will help better understand the role of the clinician in the patient scheduling process. As health centers struggle with the high turnover rate of their clerical scheduling staff, some clinicians want to engage in the scheduling process to ensure continuity of care for patients. Engaging clinicians in the scheduling process, if done correctly, may be a way to support continuity of care and clinical efficiency.

Learning Objectives:

- Describe a clinician-led, patient scheduling process at a federally qualified health center.

- Discuss clinicians' motivations for engaging in a clinician-led, patient scheduling process.

- Describe clinician experiences engaging in a clinician-led, patient scheduling process.

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Presenter(s): Dane Nimako, Ebony Whisenant

CP37

Exploring Clinician Attitudes, Knowledge, and Practices Related to Contraceptive Prescribing at a Federally Qualified Health Center in Arizona

Poster Type: Research

Description: According to the most recent data from the Centers for Disease Control and Prevention (CDC), approximately 45% of pregnancies in the US are unintended. Historically, unintended pregnancy rates are higher among women in low-income households, women aged 18-24, women who cohabitate, and women of color. Many unintended pregnancies result from not using contraception or from not using contraception consistently or correctly. To help prevent unintended pregnancies, there is a need to build the capacity for healthcare clinicians to provide quality, patient-centered contraceptive methods. The CDC endorsement of self-administered depot medroxyprogesterone acetate (DMPA-SC) for patients is an example of these efforts. While patient-centered initiatives seek to decrease barriers for

patients, factors that impact clinicians' clinical decisions regarding contraceptives must also be considered. An understanding of clinicians' clinical decision-making as it relates to DMPA-SC and other contraceptive methods is critical to improving access to evidence-based, patient-centered contraceptive methods. The purpose of this project is to explore clinician attitudes, knowledge, and practices related to contraceptive prescribing in a federally qualified health center (FQHC) in Arizona. Clinicians practicing at a federally qualified health center in Arizona were asked to complete a brief, anonymous survey via email related to contraceptive prescribing. The survey included questions to elicit clinicians' prescribing practices for contraceptive methods, concerns regarding various contraceptive methods, awareness of CDC recommendations for DMPA-SC, and desires for additional training on contraception. Clinicians were also asked to complete a brief survey regarding desires for additional training on contraceptive methods. The results of these surveys will be used to inform organizational practices aimed at supporting professional development for clinicians related to contraceptive methods with the ultimate goal of increasing access to patient-centered family planning services and contraceptives.

Principal Findings: This project is currently in-progress and data collection is ongoing. Preliminary data analysis suggests that the most commonly prescribed contraceptive methods include oral contraceptive pills, injectable birth control, and male condoms. The least commonly prescribed methods include female condoms, vaginal pH gels, and spermicides. Clinician concerns about various contraceptive methods include affordability, ineffectiveness, medical side effects, and incorrect use. While so far the data suggests that many of the clinicians surveyed prescribe injectable birth control, few are familiar with the CDC recommendations for self-administered DMPA-SC. Additionally, many clinicians are interested in additional training on contraceptive methods specifically in the areas of injectable contraceptive methods, intrauterine devices, and contraceptive implants.

How this Project/Study Benefits Health Centers: This project will help support clinicians in their clinical decision-making related to the provision of family planning services to the health center patient population. With an increased understanding of barriers from the clinician's perspective, the health center can develop interventions to address clinician-identified barriers to family planning services. Additionally, the project can help increase clinician awareness of evidence-based contraceptive options such as DMPA-SC and support the development of targeted provider education to increase clinician knowledge of these options for family planning.

Learning Objectives:

- Discuss the etiology and impact of unintended pregnancies.

- Describe clinician contraceptive prescribing practices at an FQHC in Arizona.

- Increase awareness of self-administered depot medroxyprogesterone acetate (DMPA-SC) as an evidence-based, contraceptive method.

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CP38

Hispanic Community Outreach Impact on Increasing Hispanic Participation in the All of Us Research Program - Columbia, SC, 2022-2023

Poster Type: Research

Description: Cooperative Health (CH) is a nonprofit federally qualified health center that offers primary health care services to families of the Midlands in South Carolina (SC). Since 2016, CH has been a partner of the National Institute of Health (NIH) - All of Us Research Program (AoURP), offering enrolments to participants who are underrepresented in biomedical research (UBR). We welcome participants from all backgrounds. Researchers will use the data to learn how our biology, lifestyle, and environment affect health. This may one day help them find ways to treat and prevent disease. From March 16 - September 14, 2022, we had a percentage of Hispanic participation totaling 23.61% (34 full/core enrolled participants). To increase our Hispanic enrollments, CH-AoURP initiated an outreach campaign entitled, "AoU Hispanic Community Outreach." Goal: To increase the Hispanic enrollment rate of CH patients by at least 6% over the course of a 6-month campaign period. Methods: the Hispanic Community Outreach campaign consisted of 3 unique approaches. *Approach 1:* Organized outreach events and activities with local Hispanic organizations and groups (PASOS, Hispanc Division of the Diabetes Intervention Program, Latinomas TV, Richland County School District 2 and CH Hispanic Board Representatives). *Approach 2:* Joined and contacted local social Hispanic groups (Latinos in Columbia, SC and Venezuelans in Columbia, SC). *Approach 3:* Appearance on a local Hispanic TV live Interview to promote the All of Us Research Program.

Principal Findings: The results of the campaign show a 51% increase in Hispanic participant enrollments over the 6-month time frame of the outreach campaign. The Hispanic enrollment rate increased by 21% during the same period. We exceeded our campaign goal of increasing Hispanic core participant enrollment by at least 6%. The Hispanic core participants who enrolled during the campaign overwhelmingly selected Spanish as their preferred language. Conclusion: The Hispanic outreach campaign was initiated as a 6-month strategy through participation of community outreach events and activities at

local Hispanic organizations in the Midlands of South Carolina. The results show significant improvements in the Hispanic participation in the AoURP by increasing core enrollments. This outreach campaign was successful for increasing enrollment of Hispanic participants and may be duplicated with other communities.

How this Project/Study Benefits Health Centers: By participating in the All of Us Research Program, our patients from Cooperative Health will be able to learn more about their health, including information about their DNA, including ancestry, genetic traits and certain health-related DNA (or hereditary diseases) results which they can share with their health care provider, leading to better care for them and their family members. The All of Us Research Program's foundation is an initiative called Precision Medicine, which is an approach to disease treatment and prevention that seeks to maximize effectiveness by taking into account individual variability in genes, environment, and life style.

Learning Objectives:

- List the different types of approaches implemented in the Hispanic community to increase participation in the All of Us research program.

- Identify the most important factors leading to the completion of new enrollments.

- Describe the principal findings and lessons learned from the 6-month Hispanic outreach campaign.

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CP39

Latent TB Infection Care Cascade at a Community Health Center in Seattle

Poster Type: Research

Description: ICHS is a Federally Qualified Community Health Center serving many Asian and Pacific Islander persons: 86% of the patients are from ethnic minority groups, with 76% of immigrated patients from Asia and thus International Community Health Services (ICHS) serves a large population of patients who are at high risk of latent TB infection (LTBI) and of developing active TB disease. ICHS collaborated with King County TB Control Program and joined TB Epidemiologic Studies Consortium (TBESC), a CDC-funded initiative, with the goal to better understand TB prevention activities in primary care settings, and to plan and evaluate interventions to improve TB screening and LTBI care. Through TBESC, ICHS was able to evaluate baseline TB screening rates and care of patients with LTBI ("LTBI cascade"). ICHS patients' demographic and clinical data was extracted from EMRs that

were seen from October 2021 to September 2022. LTBI care cascade steps were defined and descriptive statistics used for analysis.

Principal Findings: The baseline data showed 14% of the eligible high-risk patients were tested for TB infection. Additionally, 61% of those tested positive for TB infection completed chest radiography, 61% of those diagnosed with LTBI after radiology review were offered treatment, 67% of those who were offered treatment started treatment, and 42% of those who started LTBI treatment completed treatment. Based on current findings, the following four interventions will be implemented sequentially over the next 3.5 years through the TBESC study: (1) educational sessions and resources for medical providers; (2) funding to defray costs of testing and treatment for uninsured high-risk patients; (3) LTBI case management; and (4) electronic medical record modification to flag high-risk patients for screening.

How this Project/Study Benefits Health Centers: The largest drop off in the LTBI care cascade at ICHS was at the step of testing for LTBI among eligible non-US born, high-risk persons. As the criteria for LTBI screening are not applicable for everyone, community health centers are in a unique position to address TB prevention in this vulnerable population and have greater access and rapport to provide patients with LTBI care.

Learning Objectives:

- Understand the critical role that community health centers play in TB prevention in vulnerable populations.

- Increase TB screening among high-risk populations in a primary care setting as baseline data showed only 14% of the eligible high-risk patients were tested for TB infection.

- Improve LTBI care among high-risk populations in a primary care setting as baseline data showed only 42% of patients started on LTBI treatment completed treatment.

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Caracostis, Andrea - CP24
Casaverde Marin, Maria – CP2, CP3, CP18
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Chbib, Muhamad - CP26
Chen, Dana - CP26
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Chieng, Valerie - CP6
Chu, Sharon - CP26
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Dang, Gilbert - CP1
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Delavary, Desiree - CP26
Delgado, Candy - CP14
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Hirshman, Sara - CP28
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Hoffman, Riley - CP34
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Miller, Sarah - CP33
Minafee, Tayana - CP33
Morrison, Logan - CP28

Nakum, Nena - CP28
Nelson, Andrew - CP28
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Nguyen, Kevin - CP14
Nielsen, Christina - CP1
Nimako, Dane - CP36

Oesterle, Colette - CP37

Pennino, Adriana - CP1
Peters, Zachary - CP31, CP32
Popinchalk, Anna - CP29
Puri, Nisha - CP33

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Rabahieh, Jason - CP34
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Reyes, Ricardo - CP33
Rios, Esteban - CP14
Riser Taylor, Shawn - CP8
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Taylor, David S. - CP8
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Tong, William - CP34
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Vallangeon, Dana – CP4, CP25
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Vo, Vivian - CP1

Wagner, Ariela - CP25
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Manchester Grand Hyatt
Poster Presentations

Sunday, August 27, 2023, 5:00pm – 6:30pm   •   Monday, August 28, 2023, 12:30pm – 1:30pm
Harbor Foyer
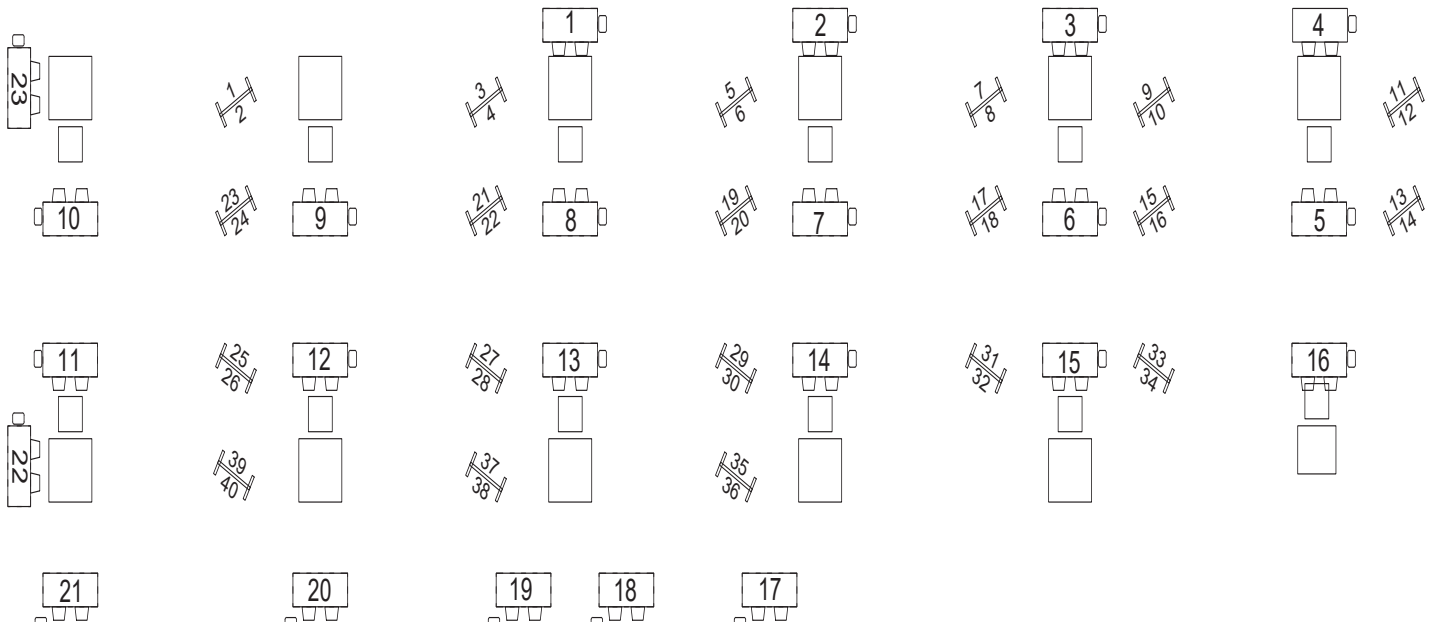
Upcoming NACHC Conferences and Trainings

MARK YOUR CALENDARS!
Check back regularly to see which events will include virtual streaming!

*(as of July 11, 2023 and subject to change***)**

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

DATES	CONFERENCE/TRAINING	HOTEL	CITY
October 24-25, 2023	Financial, Operations Management/Information Technology (FOM/IT) Conference & EXPO Preconference Workshops: October 23	Paris Las Vegas	Las Vegas, NV
November 13-15, 2023	PCA & HCCN Conference	Omni Louisville Hotel	Louisville, KY
February 12-15, 2024	Policy & Issues Forum (P&I) Committee Meetings: February 10-11, 2024	Marriott Marquis	Washington, DC
April 23-25, 2024	Conference for Agricultural Worker Health	Hyatt Regency Atlanta	Atlanta, GA
August 25-27, 2024	Community Health Institute (CHI) & EXPO Committee Meetings: August 23-24, 2024	TBD	TBD
February 5-8, 2025	Policy & Issues Forum (P&I) Committee Meetings: February 3-4, 2025	Marriott Marquis	Washington, DC
August 17-19, 2025	Community Health Institute (CHI) & EXPO Committee Meetings: August 15-16, 2025	Hyatt Regency Chicago	Chicago, IL
August 30-September 1, 2026	Community Health Institute (CHI) & EXPO Committee Meetings: August 28-29, 2026	Manchester Grand Hyatt	San Diego, CA

To register for these and future trainings, visit us at **http://nachc.org/trainings-and-conferences/**.

For additional information on NACHC Training, contact
trainings@nachc.com or meetings@nachc.com.

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Conference: October 24–25
Preconference Workshops: October 23
Hybrid Event

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