Abstracts from the
4th Annual
NYC RING Convocation of Practices

December 11, 2007
# NYC RING
Selected Abstracts
4th Annual Convocation of Practices

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NYC RING

ABOUT US
The New York City Research and Improvement Networking Group (NYC RING) was formed in 2003. It is a practice based research network sponsored by the Department of Family and Social Medicine of Albert Einstein College of Medicine. NYC RING has built to date a partnership of 24 practices in the Bronx and Manhattan sponsored by five medical centers, and one private practice, providing over 395,000 visits to primarily low-income, minority primary care patients.

WHAT IS A PRACTICE BASED RESEARCH NETWORK (PBRN)?
- A voluntary association of practicing clinicians collaborating to improve quality of care through research or quality improvement in their offices.

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

CRITICAL ELEMENTS OF NYC RING PROJECTS
- Clinically relevant to urban primary care
- Potential to change practice
- Respectful of clinician time and practice realities
- Results fed back to practices
- Opportunity for clinician and staff input at all phases

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

NYC RING WEBSITE
Please visit our website at www.nycring.org to learn more about our goals and projects.

NYC RING MEMBERS

Institute for Urban Family Health (Manhattan & Bronx)
- Beth Israel Department of Family Medicine
- Beth Israel Residency in Urban Family Medicine

Bronx-Lebanon Hospital Center (Bronx)
- BronxCare at Fulton Park Family Practice
- BronxCare Medical and Dental Ogden
- BronxCare at Crotona Park Family Medicine
- BronxCare at MBD Family Medicine

Montefiore Medical Center (Bronx)
- Montefiore Medical Group
- Castle Hill
- Comprehensive Family Care Center (CFCC)
- Comprehensive Health Care Center (CHCC)
- Family Health Center
- Fordham Family Practice
- Marble Hill Family Practice
- University Ave. Family Practice
- West Farms Family Practice
- Williamsbridge Family Practice

South Bronx Health Center for Children and Families (Bronx)

Private Practice (Bronx)
- Riverdale Family Practice (Morrow)

Urban Health Plan Inc. (Bronx)
- El Nuevo San Juan
- Bella Vista Health Center
- Plaza Del Castillo Health Center

Saint Joseph’s Medical Center
- Family Health Center (Yonkers)

North Bronx HealthCare Network (Bronx)
- The Health Center at Tremont
- The Health Center at Gun Hill
- The Health Center at Glebe
NYC RING WEBSITE

Please visit our website at www.nycring.org to learn more about our goals and projects, or to view complete posters for the abstracts that follow.
NYC RING’s Fourth Annual Convocation of Practices: Clinicians, Residents and Researchers Gather to Share their Work

To stimulate communication among NYC RING members, we asked researchers and clinicians to provide poster or storyboard presentations of their research and quality improvement projects at the 4th Annual NYC RING Convocation of Practices in December 2007. These presentations highlight work that has taken place over the last year within our practice based network. It also shows how quality improvement and research can be linked and expanded upon when clinicians and researchers share their work with each other.

This year 36 informal poster presentations and story boards were presented by teams from participating sites, residents, and investigators working in NYC RING practices. The wide range of topics important to primary care practice in the urban health setting included chronic disease, health promotion, HIV screening and service, mental health, reproductive health, wound healing, incarceration, and quality improvement.

We hope that by creating a book of abstracts from these posters and storyboards, we can help share this work among interested parties. If you find an abstract interesting, feel free to contact the author, (email addresses are on pages 46 and 47). Full posters are available on the NYC RING website at www.nycring.org.

We look forward to hearing from you about how we can help you and others to further build on this work.

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4th Annual Convocation of Practices
December 11, 2007

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Poster Session
4:30-7:30 pm

Welcome
5:30 pm

Roundtable Discussions
6:45-7:30 pm

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Abstract #1

**New York Diabetes Coalition, Translating the Chronic Care Model into Practice**
Bob Morrow, MD, Kim Kelly

**Context:** The New York Diabetes Coalition (NYDC) is a voluntary, multi-stakeholder group whose core members consist of the NYS Academy of Family Physicians, the NY Chapter of the American College of Physicians, the New York Health Plan Association and individual health plans, the State and City Departments of Health (DOH), other DOHs and community organizations. The goal of the NYDC is to improve diabetes care by supporting physicians with education, tools, and technology.

**Objective:** To improve patient care outcomes and change practice behavior through practice-based education and the implementation of a diabetes care registry using the Chronic Care Model (CCM).

**Design:** The NYDC will pilot test its program by identifying up to 25 practices in NYS interested in changing the way they deliver care to patients with diabetes. Through trained peer facilitators we will address physician barriers to practice change through interactive, practice-based education. Staff will be trained on the use of a Web-based registry (DocSite.com), given guidance regarding practice re-organization and taught what to do with patients discovered by the registry. We will measure indicators of uptake and utilization of the registry as well as patient health outcome data, such as A1C, LDL, microalbumen collection, and blood pressure.

**Results:** One practice has been identified and the education and registry have been implemented. They began with 82 patients in the registry and have identified 16 more through this process. The physicians have received interactive education and barriers to patient adherence to care guidelines have been identified and are being addressed. Patient health outcomes have not yet been evaluated.

**Conclusion:** Through a public-private partnership, the NYDC has piloted a model of robust, peer-led, practice-based interactive education and registry implementation designed to effect practice behavior and produce measurable changes in outcomes.
Abstract #2

A Collaborative Approach to Control Hypertension in Diabetes (COACH-D)
M. Diane McKee, MD, MS, Elizabeth Walker, PhD, Zach Rosen, MD, Clyde Schechter, MD, MA, Stacia Maher, MPH, Anne O’Keefe, RN, Irina Sigal, RN, Jonathan Giftos

**Context:** Strong evidence now indicates that therapy for hyperglycemia, hypertension, and dyslipidemia can prevent or delay microvascular and macrovascular complications of diabetes. The goals for management are well-defined, effective therapies are available, and practice guidelines for each have been developed and disseminated. Yet many patients, especially in poor and minority communities, do not reach evidence-based targets for blood pressure, blood glucose and cholesterol. The most common errors in chronic disease management are not prescribing the wrong drug, or omitting laboratory surveillance, but provider failure to initiate or titrate medications until evidence-based clinical goals are reached.

**Objective:** The overall goal of this translational research project is to develop a novel intervention to improve blood pressure and other intermediate outcomes of diabetes management (glycosylated hemoglobin [HbA1c] and cholesterol) in a multi-ethnic, low-income primary care population.

**Setting:** The Montefiore Family Health Center (MFHC), located in the north central Bronx, is a federally-qualified community health center employing 14 attending family medicine providers and 16 residents.

**Participants:** Individuals with a diagnosis of type 2 diabetes and a BP ≥ 140/90 measured at last visit and at least one other visit in last year.

**Design:** The cornerstone of our patient-centered intervention will be a collaboration between home health care nurses and primary care clinicians, focusing on primary care patients who remain outside guideline-based targets for blood pressure. We will employ home health nursing interventions and home telemetry units that will transmit home blood pressure and blood glucose results to facilitate intensified treatment by the primary care provider. The intervention will be guided by the Chronic Care Model(1), a model that identifies key elements for improving delivery of chronic illness care for optimal health outcomes. COACH D is designed to be feasible, economical, practical and sustainable in the urban primary care setting.

**Evaluation:** We will conduct a mixed method evaluation combining qualitative and quantitative methods to obtain home health, primary care, and patient perspectives on adoption and implementation of the intervention. Our evaluation will be guided by the RE-AIM framework(2), a multifaceted approach for evaluating the effectiveness of interventions in real world settings. Our evaluation results will be used to revise and improve the intervention in preparation for an R18 application to further develop and test the intervention in multiple inner-city primary care sites serving low-income patients.
Abstract #3

Williamsbridge Family Practice: Intensive Case Management
Jennifer Klein, RD, Noel Brown, MD, Arthur E. Blank, PhD

Context: The Williamsbridge Family Practice is a Family Medicine Residency training site that participated in the American Association of Medical Colleges, Academic Chronic Care Collaborative from 2005-2007. The Williamsbridge Family Practice site is located in the north Bronx with close to 26,000 visits per year and has over 959 patients with Diabetes. Of those patients with at least result in the past 12 months, 21% had HBA1C over 9.5%; 56% had an LDL > 100. 47% had a blood pressure reading > 130/80 (5/07 Sugarbusters Report). The Williamsbridge team developed various pilot studies using rapid cycle PDSAs to test for improvements across various diabetes measures.

Objective: To provide individualized, multidisciplinary diabetes education to high risk WB patients with an A1C > 9% and LDL > 100 and BP > 130/80. To investigate the effects of nurse lead, multidisciplinary, intensive case management approach to diabetes care in a defined high-risk population.

Design: The Intensive Case Management pilot study was based on a recent meta regression analysis of the effects of quality improvement strategies for Glycemic control (Shojania, 2006). Program start date is July 2007.

Key elements included in the design of the intervention were
- Risk stratification of diabetes population.
- Case management = coordination of treatment, arrangement of referrals, follow-up of test results, medication titration support.
- Health education and psychosocial services.
- Diabetes nurse educator with established link to Montefiore’s Clinical Diabetes Center. Diabetologist. RN telephonic support and follow-up.

Preliminary Results:
Number of patients managed = 34
- A1C increased in 4, remained the same in 4, and decreased in 26.
- Initial A1C > 9: improved by 26.9% and Initial A1C < 9: improved by 8.05%.

Limitations:
- Inclusion criteria were not strictly adhered to which may have diluted the ICM program’s effects. 10 of 34 patients were with A1Cs < 9. 2 of those 10 with A1Cs < 7.
- In July 2007 program inclusion criteria changed to A1C > 9 and LDL > 100 or BP 130/80. In August 2007 criteria changed to A1C > 9.
- Initial A1Cs were on or around 1st ICM visit.

References:
Abstract #4

**Patient Enablement Instrument [PEI] Scores and HA1C in an Outpatient Population of Diabetics**
Ram P Paneru, MD, Jose Lopez, MD, Sabesan Karuppiah, MD, Douglas Reich, MD

**Context:** The core values of family medicine are patient centeredness and holism. PEI is a good outcome measure of patient-centered care. There is a lack of study relating to PEI and disease outcome.

**Objective:** Generate new ideas for further study and relate quantitatively PCC and disease outcome.

**Hypothesis:** Determine the Correlation between PEI and HA1C among Diabetics in an Outpatient Setting. Better PEI Scores Correlates with Better HA1C among Diabetics in an Outpatient Setting.

**Design:** PEI and a short questionnaire to 105-clustered sample of diabetics from Ogden and Fulton Clinics who accepted to participate. Next, using LASTWORD, their HA1C from Jan 2006 until May 2007 were recorded. PEI Scores and PCI Scores were collected.

**Data Processing:** Scoring for PEI {Max 12} and PCI {Max 16} and HA1C data transformation {HA1C <7.0 or <7.5} and c HA1C.

**Data Analysis:** A multiple logistic regression model was used to investigate correlations and HA1C statistic was done using MS excel.

**Discussion:** PEI raw scores and HA1C <= 7 did not achieve a statistically significant correlation P < 0.076. Participants with PEI scores >4 were more likely to have HA1C <7.0 or <7.5 (OR=5.749, 95% CI (1.394 to 23.712) P=0.016). Just like PEI, participants with PCI >6 or >8 scores were more likely to have HA1C <7 or <7.5 (P=0.024 and 0.041 respectively). A change in HA1C towards a more favorable value in the last 12 months was more likely in patients with PEIS >4 or PCI >6 or >8 (0.036, 0.028, 0.021 respectively).

**Conclusion:** Average HA1C at BLHCFM clinics was 8.33 with SD of 1.66. Diabetics at BLHCFM clinics with PEI scores >4 were more likely to have their HA1C <7.0. Clinically however it sounds solid to suggest that this study has huge potential to change the way patient-centered care is presently practiced. PEI and PCI can become important tools for the evaluation of patient-centered care especially when linked with measures of disease outcomes. Further studies are suggested.

**Abbreviations:** LASTWORD-Computer program for medical record in Bronx Lebanon hospital. PEI –Patient enablement Instrument. PCC-Patient Centered Care. HA1C-Hemoglobin A1C.
Abstract #5

**Preliminary Outcomes of a Pediatric Lifestyle Counseling Intervention**
Darwin Deen, MD, MS, M. Diane Mckee, MD, MS, Stacia M. Maher, MPH, Arthur Blank, PhD, Jason Fletcher, MA, MS

**Context:** Pediatric obesity is common in urban primary care. Family-based approaches for prevention are needed.

**Objective:** Preliminary analysis of change in health behaviors after an urban practice-based intervention.

**Design:** Telephone survey, administered before and after an intervention to increase screening and counseling.

**Setting:** Six practices serving low-income patients in the Bronx.

**Participants:** Parents/guardians of 2-4 year olds.

**Instrument:** Measures of child diet and activity (PNB), adult diet (SC-N) and exercise (IPAQ), and readiness to change family and personal health behaviors.

**Results:** Of 321 baseline surveys, 156 (48%) were patients at intervention practices. Of these only 22 (14%) had preventive (well child care) visits during the intervention period, and 36 (11.2%) were screened for unhealthy behaviors using the intervention’s screening tool. Of 106 families with completed follow-up interviews to date, only 12 were exposed to the screening process during visits. Intention to treat analysis indicates that children who were patients of intervention sites have significantly better eating habits than those from control sites (p = .047), but no other differences. Focusing only on the 36 families with data to date who were exposed to the intervention, some trends are observed. Children’s diet improved (mean 12.5 to 9.9 on scale 0-29), however their outdoor activity decreased (mean 2.4 to 1.4 times/week). Adults’ reported increases in weekly vigorous (16.4 minutes) and moderate activity (66.9 minutes), yet diet did not change.

**Conclusions:** Ability to evaluate the effectiveness of the intervention will be limited by small numbers of families who could be reached to interview who also had visits during the intervention period. Trends suggest that child diet and adult activity may be easier to modify than other behaviors. Inability to change children’s outdoor activity for urban patients is concerning. Future intervention research in this setting will require major changes in data collection approach.
Abstract #6

Family Lifestyle Assessment of Initial Risk (FLAIR): Evaluation of Lifestyle Counselor Consults
Patricia Lopez, Stacia Maher, MPH, M. Diane McKee, MD, MS, Darwin Deen, MD, MS Alice Fornari, EdD, RD

Context: The prevalence of overweight among infants and 2-5 year olds is a growing concern. Eleven percent of infants 0-23 months are overweight and 22% of 2-5 year olds are overweight or at risk for being overweight.

Objective: This study was part of the Family Lifestyle Assessment of Initial Risk (FLAIR) Project. It assessed whether a brief practice-based initiative between the patient’s parent and their physician, followed up by health education consults, could effect meaningful lifestyle change among families of young children.

Intervention: After the patient was screened, the physician used brief behavioral counseling to set goals and a referral was made to the lifestyle counselor. Using the principals of MI, the lifestyle counselor developed strategies to address the barriers identified by the parent in the goal setting form and family action plan. Written notes were placed in the permanent record.

Instruments: Qualitative data was derived from goals selected by the patient and physician written nutrition/healthy lifestyle “prescription-like” notes taken by the physician on the goal setting form. Qualitative data was also derived from notes taken by the health educator during and after each meeting with parent either in-person or over the phone.

Methods: Themes were identified by two readers, and within these themes patient barriers and strategies to overcome these barriers were identified.

Results: The following themes were identified: 1) Parenting skills were a barrier to healthy eating and included picky eating and weight loss, child tantrums and speech delays, and bottle feeding beyond the recommended age. Strategies for addressing parenting skills included working closely with the social worker, providing education for the parent and suggesting creative ideas for healthy eating. 2) Parental guilt, for example as a result of being a single parent, was a barrier to healthy eating. Parents often rewarded their children with unhealthy food rewards (particularly fathers). A strategy for addressing parental guilt included working with the parent to find another means of rewarding their child. 3) Many parents did not relate to food in a healthy way and experienced confusion over what to eat. Strategies included emphasizing meals with whole grains and advising parents to find a healthy grocery store in their neighborhood. 4) Contextual issues acted as barriers. For example, many parents had symptoms of depression, unemployment and housing problems. 5) Often family members living in the same household were in disagreement over food choices. 6) Many parents were open to improving their family's way of eating and were already practicing healthy behaviors.

Implications: Parents were motivated but identified many barriers related to the urban context and environment in which they lived. The lifestyle counselor was able to establish a close rapport with parents and worked closely with the social worker.
Abstract #7

Rapid Implementation of a Quitline Fax Referral Service in an Urban Area
Steven Bernstein, MD, Saba Jearld, MPH, Deepa Prasad, MPH, Patricia Bax, RN, MS

Objective: Despite known efficacy, the state Smokers' Quitline was poorly used by Bronx providers. Our objective was to develop, implement, and evaluate a multicomponent intervention to increase the use of fax referral services to the New York State Smokers' Quitline.

Setting: Bronx, NY - Hospitals, Ambulatory Care Centers, Community Health Care Centers

Intervention: In late 2004, the New York State Department of Health created 19 tobacco control centers around the state, charged with providing training and technical assistance to individual providers and health care systems. In January, 2005, the Bronx tobacco control center began to offer provider education, assistance with systems change, audit/feedback, a website tailored for local providers, regular meetings and communications, and a competition among clinical sites to increase the visibility and use of the fax referral program.

Results: Prior to program onset, no Bronx providers made fax referrals to the Quitline. After a three-month run-in period, a steady monthly increase was noted; since April, 2006, an average of 80 monthly referrals have been made by Bronx providers. In 2006, 906 fax referrals were made by Bronx providers to the Quitline, representing 0.5% of all Bronx smokers. This usage exceeds that of any other county in the state with a population greater than 500,000. Many sites have introduced systems changes to integrate fax referrals into routine clinical and administrative workflow.

Conclusions: A multicomponent program consisting of training, systems change, chart audit and feedback, friendly competition, and frequent communication can lead to a sustained increase in the use of Quitline referral services by disparate groups of health care providers.
Abstract #8

Enhancing Delivery of Confidential Care & Sexually Transmitted Infection Screening for Adolescents in Urban Health Centers
M. Diane McKee, MD MS, Susan E. Rubin, MD MPH, Elizabeth Alderman, MD, Lucia O’Sullivan, PhD

**Background:** Adolescents in poor, inner-city neighborhoods are at considerable increased risk for pregnancy and sexually transmitted infections (STIs). However, delivery of preventive services is inconsistent, with sexual health services especially variable. Despite urgent need for confidential care, many youth report they have not spent time alone with health care providers and few adolescents are aware of the right to confidential care. Confidential health care is essential if adolescents’ health care concerns are to be met

**Objectives:** In preparation for a larger randomized controlled trial, our primary objective is to: Develop, implement and evaluate a practice-based *pilot intervention* to increase rates and timeliness of STI screening sexually-active of urban adolescents by improved access to confidential services in urban primary care.

**Methods:**
- **Year 1 Formative Research – Focus Group:** Groups will be held with mothers and, separately, for their adolescent sons recruited from six MMG clinics. Iterative development of topic guide to include issues around experiences with confidential care & expectations from the health care system.
- **Year 1 Formative Research – PCP Card Study:** PCPs randomly selected from providers at four sites will complete 10 index cards immediately following adolescent visits. These cards pertain to provision of care during that specific adolescent visit. They will be followed by an in-depth interview with provider to explore adolescent and parent interactions, confidential care and reproductive/sexual health care.
- **Year 2 - Pilot Intervention with Intervention and Control site:** A three-pronged structure to 1) train physicians to routinely and consistently provide confidential care and assess sexual health, 2) increase adolescents and parents awareness of the need for & availability of confidential care, and 3) implement clinic level improvements in appointment, reception and billing procedures to create environments more conducive to confidential care.
- **Year 2 - Pilot Intervention Evaluation of Process:** Assess the 1) feasibility of the intervention, 2) barriers to adoption in different settings, and 3) acceptability to health care providers, staff, parents and adolescents.
- **Year 2 - Pilot Intervention Evaluation of Outcome:** Obtain preliminary estimates of: 1) the efficacy of the intervention to enhance exposure to confidential care, 2) providers thorough risk assessment -including adolescent disclosure of sexual activity to health care providers, and 3) improvement in screening for STIs among sexually active youth.

**Outcomes to be Measured:** We will compare intervention and control sites for rates of: 1) STI screening in adolescents, 2) adolescent confidential care visits, and 3) PCP addressing adolescents sexual activity “status”.

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Abstract #9

Effect of Resident Education and Clinic Reminders on Resident Management of Obesity
Nichola Davis, MD, MS, Clyde Schechter, MD, MA, Judith Wylie Rosett, EdD, RD

Context:  Resident physicians report feelings of incompetence in treating obesity and do not routinely counsel patients or refer patients for weight management.

Objective:  To determine if a combined intervention of resident education and clinic based reminders is superior for improving resident knowledge and management of obesity when compared to a resident educational intervention alone.

Setting & Participants:  The educational intervention involves 60 Internal Medicine and Family Medicine residents (to date).  The clinic intervention includes Comprehensive Family Care Center and Williamsbridge sites of Montefiore Medical Group.

Intervention:  This is a 2 component intervention.  The resident educational intervention is a 2 hour educational session which instructs residents on how to counsel obese patients, demonstrates use of counseling tools, and how to use motivational interviewing techniques to assess patients’ motivation for change.  Residents are given an opportunity to practice counseling techniques.  The clinic intervention is a minimal intervention designed not to increase clinic staff burden.  Clinics were randomized to receive obesity management tools which included BMI charts, food fitness wheels, and patient brochures.  Control clinics did not receive any management tools.

Outcome Measures:  The primary outcome is change in resident knowledge assessed by questionnaire done prior to and immediately after educational intervention.  Secondary outcome is change in resident management of obesity as assessed by chart review.

Preliminary Results:  Approximately 60 residents have completed educational intervention, and pre and post test questionnaires of knowledge.  Data collection is ongoing.
Abstract #10

Optimizing Screening for Hepatitis C in Primary Care: An AHRQ Action Network/Center for Disease Control-Funded Project

Context: An AHRQ Action Network/Center for Disease Control-Funded Project. Since 1998, the Centers for Disease Control and Prevention (CDC) has recommended that anti-HCV testing should be routinely offered to persons most likely to be infected with HCV. The highest prevalence of anti-HCV is in persons born between 1945-1964; 69% of anti-HCV positive persons identified were in this birth cohort (NHANES).

Objective: This study will evaluate whether providers in three large health centers are routinely offering HCV screening the added yield of targeted screening of the 1945-1964 birth cohort, and whether providers can increase testing uptake by better identification of behavioral risks. Primary objectives include evaluating PCP HCV screening practices to adequately and efficiently identify persons who could benefit from HCV screening and to examine the feasibility, sensitivity, and specificity of birth cohort and other risk categories to detect previously unidentified HCV-infected persons.

Setting: NYC RING sites involved in the project are the Comprehensive Family Care Center (CFCC), the Comprehensive Health Care Center (CHCC) and the Family Health Center (FHC).

Design:
• Develop and implement an intervention that is appropriate for each site through practice site visits, focus groups with providers, and key informant interviews with staff and providers in order to enhance identification of risk factors and screening when appropriate.
• Collect baseline data through chart review for risk factor identification, CIS abstraction of visit history and HCV and other lab results.
• Simple practice-based interventions to be determined in consultation with the practices and birth cohort based screening.
• Collect post intervention data through chart review for risk factor identification and CIS abstraction of visit history and HCV and other lab results.

Study Outcomes: Outcomes assessed are proportion of anti-HCV positive patients who are identified using a multiple category self report-risk assessment screening that includes a) an estimate of the proportion of anti-HCV positive patients, b) birth cohort as a single risk for infection, or c) a behavioral risk assessments in combination with targeting the age cohort. Additionally, the cost per anti-HCV positive person identified using the cohort based and multiple risk based screening and the cost per anti-HCV positive person identified if all persons with elevated ALT were tested with being assessed.

Next Steps: Conduct focus groups and qualitative interviews with clinic staff to inform risk assessment questionnaire and specifics of intervention (specifically tailored to each clinic). Finalize chart extraction instrument and protocols (protocols unique to each clinic). Finalize which data elements are available through electronic medical record (EMR) and which are available only through chart extraction. Conduct baseline evaluation.
Abstract #11

**Infant Feeding & Infant Health: 2 Randomized Clinical Trials**
Karen Bonuck, PhD, Peter Bernstein, Kathy Freeman, DrPH, Rebecca Williams, MD, MHPE & Jenny Lischewski, MPH

**Objective:** Advance Healthy People 2010 breastfeeding goals by testing the effectiveness of prenatal care-based interventions to promote breastfeeding as part of routine prenatal care.

**Design:** Randomized controlled trial(s) at Montefiore Medical Center’s Comprehensive Family Care Center (CFCC) and the Centennial Women’s Center. Interventions include: Lactation Consultant (LC) &/or Prenatal Care Provider (PCP). The CFCC will enroll 666 women, randomized to 1 of 4 groups: a) LC, b) PCP, c) LC + PCP, or d) Control. Centennial will enroll 275 women, randomized to 1 of 2 groups: a) LC + PCP, or b) Control.

**Participants:** English or Spanish speaking women aged 18+ years of age with routine (i.e. non-high risk) pregnancies, who receive their care at the sites and consent to study enrollment.

**Interventions:**
- **Lactation Consultant**
  - *Prenatal*- on-site LC schedules 2-3 sessions (~ 30 minutes) w/woman same day as provider appointment.
  - *Hospital*- daily rounds at Weiler Hospital to provide technical assistance.
  - *Postnatal*- home visits, phone support, and study-provided breast pumps, nursing bras, and educational materials
- **Prenatal Care Provider**
  - Electronic prenatal medical record will prompt the PCP to raise 10 “Talking Points” re: breastfeeding & infant health with participants in selected groups. Examples:
    - *What are your plans for BF?*
    - *What are your concerns about BF?*
    - *What have you heard about how much/long to BF?* (Clarify goal= 6 months exclusive)

**Outcomes (To Be Assessed):**
- **Primary Outcomes**
  - Breastfeeding exclusivity up to 6 months
- **Secondary Outcomes**
  - Infant health visits- GI, respiratory, otitis media
  - Infant Growth up to 12 months- Growth patterns of BF infants are protective against obesity in later life.
- **Elicit Feedback**
  - From providers & participants in RCTs

**Discussion:** Anticipated start date of January 2008.
Abstract #12

Characteristics of Primary Care Patients Referred to Nutritionist and Predictors of Attendance
Vivien Leung, MD, Nichola Davis, MD, MS

Context: Optimal strategies for obesity management in primary care continue to be debated. Multi-disciplinary approaches involving a primary care physician and on-site nutritionist are proposed, but have not been well studied. At the Comprehensive Family Care Clinic in the Bronx, NY where there is an on-site nutritionist, it is estimated that only half of patients scheduled for initial nutrition consultation keep their appointment. The purpose of this study is to examine the characteristics of patients being referred to nutrition and to identify predictors of attendance.

Methods: Consecutive patients referred to nutrition over a 6 month period (December 2006 - May 2007) were identified from the clinic scheduling database. Patients who “attended” and “did not attend” appointments were invited to complete a 21-item telephone survey which included patient demographics, knowledge of nutritionist appointment, reasons for not attending appointment, beliefs about nutritionist, and perceived reasons for being referred to nutritionist. Comorbid illnesses and patient BMI (body mass index) were confirmed by chart review. Chi-square tested associations between independent variables including gender, perceived reason for referral, and beliefs regarding nutrition counseling with dependent variables “attended” and “did not attend” appointment. Logistic regression determined Odds Ratios of significant associations while controlling for age, gender, and BMI.

Results: During the six month period, 210 new patients were referred to nutrition, and 138 (65%) attended their initial appointment. 111 patients (49% attended) were able to be contacted via telephone and were invited to participate. 71 patients (52% attended) completed the questionnaire. Participants who attended and did not attend their appointment were similar in mean age (45.7 ±13.6), and mean BMI (38.7 ± 10.7). The majority (69%) of participants were female. The perceived reasons for referral were weight loss (67%), diabetes (57%), hypertension (29%), and high cholesterol (22%). 24% of patients did not have any comorbid conditions besides overweight or obesity. The major reason reported for not attending initial consultation was being “too busy” (49%). After controlling for age, gender, and BMI, patients were more likely to attend their appointment if they thought they were being referred for diabetes management OR=3.9 (95% CI 1.3-11.7), or if they believed a nutritionist could help them lose weight OR= 3.3 (95% CI 1.05-10.5). Patients were less likely to keep their appointments if they believed they were being referred for weight loss alone OR=.142 (95% CI .033-.607). Hypertension and hyperlipidemia were not significant predictors of patients keeping nutritionist appointments.

Conclusions: Our results suggest that patients who believe they are being referred for diabetes management and who believe that a nutritionist can help with weight loss are more likely to keep their initial nutrition appointments. Patients who believe they are being referred for weight loss alone are less likely to keep nutrition appointments. Physicians may need to emphasize to patients that obesity in the absence of other comorbidities is still a chronic condition requiring treatment. Our findings may also suggest that physicians need to take a more active role in weight loss counseling for obese patients without comorbid illnesses as they may be less likely to attend nutrition consultation.
Abstract #13

Improving Use of Oral Health Services: Project TEETH
Niko Verdecias, MPH, Paul Meissner, MSPH, Arthur Blank, PhD, Joan Grcevic, DDS, Alison Karasz, PhD, Robert Beil, MD

Introduction: Project TEETH was designed to increase the number of HIV patients referred to and utilizing dental services at ten Montefiore Medical Group (MMG2) sites. Project TEETH is funded through a five year Federal HRSA SPNS grant.

Objective: Our primary goal is to improve oral health (OH) care delivery to an HIV+ population. To accomplish this we delineate three objectives: a) Design and implement an integrative model of OH care; b) Increase usage rates of OH services in an HIV+ population; and c) Using a QI orientation and the RE-AIM framework to evaluate our model of dental primary care in terms of its reach, effectiveness, acceptance, implementation and maintenance.

Program Description:
- Project TEETH is a collaborative between three Montefiore Medical Center departments: Family and Social Medicine, Dentistry, and the MMG2 CICERO program. The project is being conducted at the ten MMG2 sites of which three have existing dental service facilities on/near site. At the seven sites without dental facilities, the Department of Dentistry has implemented a mobile dental unit (MDU) to provide OH services. A Dental Hygienist (DH) has been integrated into the MDU operation to act as the liaison between primary care and OH care for HIV+ patients.
- The remaining three sites have Patient Navigators (PN) who act as a liaison between medical care and OH care services for HIV+ patients, assist with the dental appointment process and perform educational and follow up functions as needed. For evaluation purposes, the DH and PNs are also conducting survey-based interviews with at least 300 patients over the project’s life. We will also conduct frequent QI-based evaluations to monitor the entire program and all of its patients.

Conclusion: Data collected will allow us to determine the successes and glitches in the program to aid in improving our program’s functioning and sustainability. We anticipate that all 1000+ HIV+ patients that regularly receive primary care at the MMG2 sites will have been screened, referred, and/or received dental services by the completion of the program. Moreover, by integrating into the existing medical and dental services we will be able to provide additional support towards HIV+ patients’ comprehensive care.
Abstract #14

Bethany Doran, MD, Joseph DeLuca, MD, Galit Sacajiu, MD, Ramin Asgary, MD, and Chinazo Cunningham, MD

Context: HIV is a pressing issue in the US, with an estimated 24-27% of the more than 100,000 people currently living with HIV in the US unaware of their status. Studies have shown substantial public health benefits through reduced risk behaviors and HIV transmission by persons aware of their HIV positive status. Although rates of new HIV infection have decreased in populations generally targeted for testing and classified ‘at risk’ (males who have sex with males, injection drug users, etc.), rates of infection have increased in populations not classified ‘at risk’. To address this growing problem, the CDC recently issued revised recommendations for HIV testing in 2005, suggesting that HIV tests be given on an opt-out basis (patients are told they will be given an HIV test unless they refuse) rather than the current opt-in system.

Objective: Our clinical intervention assessed whether these guidelines are feasible in an inner city population, and characteristics of individuals more likely to accept or refuse HIV testing.

Design: We recorded whether patients chose to opt-out as well as reasons for doing so, and extracted and analyzed patient information from medical charts using chi square and t-tests.

Results: We found that 30% (61/202) patients accepted HIV testing using an opt-out approach, and patients accepting testing were more likely to have had a blood test during the same visit, had sex within the last 3 years, and/or had 1-3 partners within the last year. In addition, when interviewed as to the reason why they chose to opt-out of the HIV test, patients were most likely to say that they did not feel at risk (81%) as opposed to not wanting a blood test (6%), or not having enough time (6%).

Conclusions: We found that HIV opt-out testing was feasible in inner city populations, and the opt-out system was an effective means for increasing patient awareness and testing for HIV.
Abstract #15

Utilizing Clinical Looking Glass® for Improving the Quality of Care of HIV Infected Patients in a Network of 10 Community Health Centers
Asif M. Ansari, MD, Sara O. Briller, PhD, MPH, Robert S. Beil, MD, Bruce Soloway, MD, FAAFP, Arthur E. Blank, PhD and Peter A. Selwyn, MD, MPH

Research Objectives: To create a cohort of HIV+ patients within Montefiore Medical Group II (MMGII). To determine which patients in our cohort are on HAART and opportunistic infection prophylaxis, and to perform these tasks accurately in a more time-efficient manner. This was done utilizing Clinical Looking Glass® (CLG®).

Study Design: We compared cohort building using billing information to cohort building derived through CLG®.

Participants: HIV positive patients within MMG II. These patients are cared for by the CICERO program, a multi-disciplinary team specialized in providing care to HIV positive individuals in a community setting.

Results: The use of CLG® for cohort building yielded clean, comprehensive and timely data, superior to that derived through the billing data. Prior to 2006 an HIV+ patient list derived from billing data was created. A chart abstractor, requiring four months, supplemented clinical information pertinent to QI. CLG® performed this task instantaneously. Information obtained from CLG® was used to detect variations from clinical protocols prompting timely notification to healthcare providers, and possible remediation. Additionally, CLG® yielded a consistently larger cohort as compared to that captured by using administrative data. Using administrative (billing) information systems yielded 767 patients in 2005 as compared to 976 patients derived through the CLG® for the same time period (2005).

The ease of data analysis enabled the following QI approaches:

- **Patients on ARV / HAART.** Using CLG® we created a list of HIV medications. We delineated a sub-cohort of patients that were on HAART and subsequently reviewed patients who had detectable viral loads. This prompted clinical intervention, if so warranted.

- **Opportunistic infection prophylaxis.** Using CLG® we created a list of patients not on clinically indicated prophylaxis based on CD4 counts. This also prompted possible clinical intervention.

Conclusions: The use of CLG® is superior in all respects to the use of administrative data for the creation of a designated population of HIV positive patients within our network. CLG® captured patients that were not originally included in our cohort making for a more comprehensive panel of patients.

Relevance to Practice: The use of CLG® provides a quick and reliable method of collecting patient information. CLG® provides instantaneous information to individual Health Centers and clinicians for hands-on and continuous quality improvement work. Future uses will include other parameters such as patient retention.
Abstract #16

Understanding Physician Decisions About Depression Treatment: The Role of the Endogenous-reactive Distinction
Alison Karasz, PhD

**Context:** Guidelines for the treatment of depression in primary care settings, like the current classification system for depressive disorders, emphasize a unitary model of depression. Yet evidence suggests that many primary care physicians distinguish conceptually between ‘endogenous’ depressions, of putative biological origin, and ‘reactive’ depressions originating in life events and situations. This issue may be relevant to understanding current low rates of depression treatment in primary care. It has not been explored directly in previous studies.

**Objectives:** To explore: (1) whether physicians perceive a distinction between biological and non-biological depressions; (2) the patient variables and contextual factors shaping this perception; and (3) implications for physician decision-making. Design: qualitative interviews, including case review.

**Setting:** An urban, academic family medicine clinic serving patients from a broad range of ethnic and socio-economic backgrounds. Participants: 7 family physicians have been interviewed so far in this ongoing study.

**Results:** Results to date indicate that most family physicians in the sample make a conceptual distinction between biological and non-biological depressions. Unsurprisingly, given the current dominance and prestige of the unitary model, physicians rarely clearly articulate this distinction. A variety of patient cues seem to influence physician perceptions: the salience of social factors, the type of onset, pattern of symptoms, and patients’ requests for treatment. The distinction between biological and non-biological depression subtypes appears to shape decision-making about treatment. Physicians are more likely to prescribe medications when they classify the depression as ‘biological,’ in part because they believe that only biological depressions will respond to pharmacological treatment.

**Conclusions:** If it can be demonstrated that primary care physicians make a distinction between biological and non-biological depressions, this finding has important implications for understanding the management of depression in primary care settings. It may help to explain low rates of anti-depressant prescribing, and to suggest a wide variety of new research questions.
Abstract #17

**Integrating Depression Treatment in Primary Care: Team Las Mariposas**
Arthur Berger, EdD, Deborah Lester, LMSW

**Context:** The HRSA Health Disparities Collaboratives has a systems-approach to change in organizations, which has been applied to depression. Our organization successfully improved the treatment of depression by applying the Care Model, Model for Improvement (PDSA) and Learning Model to change the process of depression care. The team adopted measures based on evidence-based guidelines used by the national depression teams. The team initially used a population of focus of patients from one PCP with a diagnosis of Depressive Disorder/Major Depressive Disorder (ICD 9 code of 311).

**Objective:** To develop an effective process for screening and treating patients with depression in a primary care setting.

**Design:** Patient Health Questionnaire (PHQ-9), an evidence based depression screening tool, administered at point of care.

Participants: The registry initially included 163 patients but has currently increased to 713 patients.

**Intervention:** The PHQ-9 is administered. Patients who score a 5 or more on the PHQ-9 are entered into the depression registry. Those with a score of 10 or more (Clinically Significant Depression) are targeted for early intensive services (psycho-therapy, pharmacotherapy, telephone support, case management). Case managers’ work collaboratively with providers, set self management goals with patients, and rescreen patients at set time intervals. Registry data graphs are generated and analyzed monthly by the team.

**Results:** The registry contains 713 patients, with 410 patients classified as having Clinically Significant Depression (CSD). The national outcome measure definition is that 50% of CSD patients achieve a 50% reduction in PHQ score. The team achieved a 57% reduction in PHQ score and sustained this result over two-years. In addition, 53 % of patients report improved day to day functioning (secondary outcome), and 94% of patients have established a self management goal (secondary outcome).

**Conclusions:** By utilizing a combination of provider training and support services (eg: depression case managers), patients can be proactively screened and successfully treated for depression in a primary care setting.
Access to a Mental Health Home for Latino Children in the South Bronx
Anagha Loharikar, MD, Sandra Braganza, MD, Iman Sharif, MD

**Context:** Appropriate and culturally-sensitive mental health care for the Latino community in the South Bronx requires an understanding of the community needs and collaboration between community-based organizations and health care providers. Through this AAP CATCH planning grant, we aim to create a mental health home for Latino children and their families.

**Project Objectives:** 1) To determine the current barriers to accessing appropriate and culturally-sensitive mental health care for Latino children and families in the South Bronx. 2) To expand access to adequate and comprehensive mental health care for Latino children and families. 3) To improve communication between primary physicians and mental health providers.

**Target population(s):** The target population is the Latino community served by the Comprehensive Health Care Center (CHCC) in the South Bronx, serving 330,000 individuals in the most impoverished urban congressional district in the United States. Thirty-five percent is under age 18, and 63% is Latino. Approximately 43% of children in the community are living below the poverty line. The Surgeon General estimates 21% of U.S. children have a mental health disorder associated with at least minimal impairment; this rate is estimated to be even higher for the Latino population and impoverished communities.

**Project Description:** Through a thorough community needs assessment, we can understand the existing barriers to a mental health home for Latino children in the South Bronx. Next, through sustainable partnerships with community-based organizations and mental health providers in the South Bronx, we are implementing a task force to address these barriers. This coalition will identify Spanish-speaking and Latino mental health providers in the community who can best serve our population. This initiative seeks to utilize creative means of outreach to the community, including media, community meetings, church groups, school programs and health fairs, creating safer venues for discussing mental health.

**Methods/Strategies:** 1) Needs Assessment: A. Facilitation of two focus groups and 3-4 in-depth home visit interviews with Latino families. B. Facilitation of independent focus groups with pediatrician and mental health providers in the South Bronx. 2) Formation of a coalition between health care providers, mental health providers, community-based organizations, and families to address barriers to accessing mental health for this target population. 3) Based on analysis of the results of the needs assessment, through a task force within the coalition, we can identify priorities and develop strategies to empower the community to create comprehensive medical homes, including appropriate mental health services.

**Results/Impact:** An understanding of specific barriers affecting delivery of comprehensive mental health care for our South Bronx Latino community will help inform the coalition how to improve access to mental health care for Latino children. Improved communication between parents, primary care providers, and mental health providers regarding the cultural needs of the community and understanding of the etiology of illnesses and treatment plans will create the foundation for an ongoing collaboration and sustainable mental health home.

**Conclusion/Key Lesson(s) Learned:** Mental health is an integral part of comprehensive health care, which needs to be addressed through a multi-faceted approach via a coalition between health care providers, community-based organizations, patients and families. Despite our best intentions as providers, we are currently unable to resolve the deficiencies of the local mental health system, which limits our ability to provide optimal comprehensive care to our patients. Our goal is for this project to help address existing barriers to accessing mental health care in our community, specifically for the Latino community. Furthermore, we hope that this program will serve as an innovative model for bridging the widening cultural gap between health care providers and Latino patients in all aspects of health care. We anticipate that this project will begin a long-term collaboration and development of mental health resources within the South Bronx community for Latino children and families.
Abstract #19

Exploration of Mental Health Need at the Family Health Center: Results of a One Week Card Study
Joanna Dognin, PsyD, Eliana Korin, Dipl, Psic, Paul Meissner, MSPH

Introduction: Medical and psychosocial problems are often intertwined, putting primary care physicians in a unique position to detect emotional difficulties and to refer their patients to appropriate mental health services. Yet, this process is often complicated by a serious lack of resources in our communities.
To address this gap, we formed an interdisciplinary workgroup to discuss improving access within and outside of our health center. This workgroup developed and implemented a needs assessment, in the form of a card study, conducted at the Family Health Center, a Montefiore primary care center located in an impoverished section of the Bronx.
Methods: We invited 37 primary care providers to participate in our card study over a one week period in June 2007. Providers were asked to complete one card per patient for 10 consecutive adult patients. The card contained 4 questions querying the provider's perception of whether their patient had a psychosocial problem, were in distress, were in mental health treatment, whether they had referred their patient to services, and whether they would refer in house if appropriate services were available. We aimed to collect 200 cards for this analysis.
Results and Conclusions: We collected 265 cards, of which 238 were complete and used in the analysis. Providers identified a mental health need in 42% of the cards returned. The majority of patients (73%) were currently in distress, and 22% had been given a mental health referral in the past year. The vast majority (92%) had providers who would have made an in-house referral if appropriate services were available, and 26% were currently receiving any mental health services. Providers believed they were receiving all necessary services in 54% of these cases. Insurance status may be related to who was currently receiving services. Compared to those with a needs-based policy, fewer patients with commercial insurance, and no uninsured patients, were currently in mental health care. We learned that access to appropriate mental health services are indeed lacking at the Family Health Center.
Abstract #20

**Bronx-Lebanon Hospital Center Progress Report: Characteristics of High-Cost Patients**

Steven Anderman, Jeffrey Levine, MD, Douglas Reich, MD, Dana Ladogana, Jose Lopez, MD, Michael Gordon, MD, Ric Curtis, PhD, Yolanda Martin, John Billings, JD

**Background:** Within the New York State Medicaid Program, a relatively small number of patients (3%) account for a significant proportion (30%) of the healthcare expenditures. A previous trial in Great Britain employed a specific identification tool, Patients at Risk for Re-Hospitalization model (PARR), which demonstrated utility in targeting high need patients for the provision of additional, preventive services. PARR is a regression analysis of all patients from a given healthcare system using 5 years of data to provide a predictive model. Variables include most common chronic illnesses, mental health and substance abuse diagnoses, demographics, and prior utilization pattern, prior costs. 6,167 individuals were found to be at 75+% risk of re-hospitalization after index inpatient episode; 1,203 at 85+. Chronic mental illness was present in nearly half; substance abuse in two-thirds. High rates of homelessness or unstable housing were evident. This study concluded that improvement in the care of high-cost Medicaid patients will require integrated care and attention to housing.

**Objective:** The UHF High Cost Care Initiative is a consortium of NYC Hospitals (Montefiore, Bronx-Lebanon, Bellevue, Maimonides, Woodhull) with preliminary funding from the United Hospital Fund of New York City to study high-cost Medicaid patients. The first phase of this study sought to interview 100 inpatients found to be at high risk of re-hospitalization; below are some of the results of the initial 53 patients.

**Results:** Of the initial 53 patients, the average age was 48, 50% were Latino and 42% were Black, 51% were male and 72% spoke English. 15% had less than a 9th grade education and 51% had some high school or had finished their GED. 15% were living in a homeless shelter, 23% were living with friends or relatives, and 91% were unemployed. 66% were receiving financial assistance through SSI. More than 25% were hungry a lot or sometimes in the last 30 days and 43% were financially considered very poor. 60% had symptoms of depression and 30% had symptoms of mood disorder based on the PHQ 9 and the MDQ.

**Conclusions:** Further qualitative studies need to be conducted that ask: 1) what are the specific barriers and needs, 2) how will we overcome mistrust, 3) are patients interested in intensive care management, 4) are there discrete phenotypes, and 5) what do they want, really?

**Next Steps:** Chronic illness care needs to be integrated with: mental health care, substance abuse treatments, community/home assessment, and tenacious management. The next two phases of this project will try to address these needs. We will implement phase II, which is integrated family medicine/psychiatry primary care that will include 3 PCP’s, 2 psychiatrists, 3 LCSW, 1 nutritionist that will be available 24/7. Phase II will also include intensive wellness for HCCI patients through a multi-disciplinary treatment team plan carried out in less than 2 weeks from initial visit, assertive home care outreach, patient registry tracking goals and enhanced in-reach to ED/Inpatient/Psych and SA Services. As well as intensive self-management support via Illness Management and Recovery (Dartmouth Psychiatric Research Center). Phase III is a joint NYS DOH Proposal with Monte/Bronx-Leb to identify 3,500 Monte/BLHC/OLM Medicaid patients with risk score 50+ and enroll in intensive management.
Abstract #21

VCAT: Vaginal Complaints Algorithm Trial (Pilot)
Matt Anderson, MD, MS, Andreas Cohrssen, MD, Kathy Klink, MD, Yael Swica, MD, Nancy Bassett

Context: The literature on vaginitis recommends that vaginal complaints be diagnosed prior to treatment. Many clinicians do not follow this advice and treat empirically. The current algorithm often fails to make a diagnosis. We wondered if women presenting initially with vaginal complaints could be managed based on their symptoms alone.

Objective: VCAT is an RCT in primary care designed to determine if symptomatic management of vaginal complaints produces equivalent clinical outcomes to the suggested management based on pelvic examination, pH and wet mount.

Setting: Practices involved included Montefiore Family Health Center, Phillips Family Practice, Beth Israel, and Columbia Presbyterian Medical Center Family Medicine. These three practices had a long history of collaboration in this field.

Method: A randomized control trial that included premenopausal, non-pregnant women over 21 presenting initially with vaginal complaints were eligible. Those patients that exhibited fever or pelvic pain were excluded from the study. All women were screened for GC/Chlamydia and Trich. Six arm: “primarily itching” treated with anti-fungals, “primarily odor” treated for BV. If neither or both patients offered tx for both BV and candida. Control arm was treatment based on wet mount. Currently, the Family Health Center has finished enrolling 40 patients.

Measures: Primary outcome measure: self-reported symptom resolution at 2 week post-visit follow-up. Secondary outcomes: need for revisit, ADR to medications, satisfaction with visit, vaginal symptom score, dx of trich/GC/Chlamydia. We are also looking at distribution of symptoms, clinical findings, and diagnoses.

Preliminary Results: The symptom-based algorithm provides equivalent symptom relief at 2 weeks compared to the standard algorithm.

Conclusions: Our preliminary data suggests that in selected patients treatment based on symptoms may be a reasonable option. We have not analyzed all the data and have not completed research at two of our study sites. The next steps are to complete the pilot study, revise protocol in light of pilot, revise our symptom score with assistance from psychometrician, and look for other sites where we can enroll more patients rapidly.
Abstract #22

Are Unexplained Vaginal Symptoms Associated with Psychological Distress?
Andreas Cohrssen, MD, Uzma Aslam, Matthew A. Anderson, MD, Allison Karasz, PhD

Background: Vaginal complaints are common accounting for 10 million office visits annually. Despite comprehensive microbiological assessment in 25 to 50% of cases no infectious pathogen is identified. Vaginal symptoms are often associated with anxiety and effect on social and sexual functioning. A recent study in a South Asian community has shown associations of vaginal discharge with psychosocial factors, such as psychosocial stress.

Objectives: This study had two aims: 1) To explore the relationship between psychosocial factors and the presence or absence of a definitive microbiological diagnosis of vaginal complaints 2) to determine whether a 2-week follow-up is necessary or 1-week f/u suffices.

Methods: Quantitative correlation between results of PHQ-9 (depression/anxiety/somatization/stress scale), Vaginitis Complaint Scale and microscopy and/or vaginal cultures.

Participants: Women between the ages of 18-45 years.

Results: Forty-six patients were enrolled, 38 with definitive diagnosis (17 BV, 17 candida, 4 trich), one patient diagnosed by culture and 8 were undiagnosed.

Symptom resolution:
Wk 0: 10.3 (+/- 2.9)
Wk 1: 6.1 (+/- 1.6)
Wk 2: 5.9 (+/- 1.3)

No difference in psychosocial distress between those with a diagnosis and those without.

Conclusions: Patients with undiagnosed vaginal symptoms did not have more somatization, anxiety or stress. Most symptoms resolve within the first week (no significant change from wk 1 to 2).

Lessons Learned: A problem was that recruitment was less than one third of the total number of potentially eligible patients. Solutions for this problem included incentives for nurses, offering the researcher extended hours, and increasing the number of stake-holders. A PBRN offers more support for planning the project and working with a group helps keep thinking energized, however data crunch off premises can delay results.

Next Steps: There is a need to develop new hypotheses for origin of vaginal complaints in patients without a pathogen diagnosis.
Abstract #23

Access to Early Abortion Services: Patient Perspectives from an Urban Abortion Clinic
Susan E. Rubin, MD MPH, Marji Gold, MD

Background: In the United States half of all pregnancies are unintended and about 1.3 million pregnancies annually are terminated by abortion. It is estimated that 1/3 of women will have an abortion in their lifetime, making elective abortion the most common surgical procedure among reproductive aged women in the U.S. There is, however, a shortage of abortion providers. While many primary care physicians (PCPs) offer some reproductive health services, few offer abortion care. There has been a movement from some PCPs to integrate abortion services into their primary care clinics.

Objectives: To determine 1) If women of reproductive age in an urban, inner-city abortion clinic would accept abortion being offered in their “regular” medical office. 2) If available, would women choose to have an abortion with their “regular” physician in their medical office or at a free-standing specialized abortion clinic.

Methods: Using a convenience sample of women awaiting first trimester abortion services at an abortion clinic in the Bronx, we administered an anonymous survey with open & closed ended questions.

Results:
- 57% (n=86) support suction/surgical abortion being offered in their “regular” medical clinic. Most frequently cited reason has to do with choice of type of abortion procedure.
- 67% (n=101) support medication abortion being offered in their “regular” medical clinic. Most frequently cited reasons supporting medication abortion have to do with procedure issues – “because it’s just medication, it’s not performing an operation in a clinic; they’d be better equipped to do the medication.” (R#141) – and convenience.
- 47% (n=71), if given the option would choose to have a future abortion with their PCP in the PCP clinic as opposed to an abortion clinic. Most frequently cited reason has to do with issues around PCP: “(PCP) already has a record of everything and I’m comfortable with my doctor” (R#18).

Discussion: Medication abortion, as opposed to suction abortion, appears more acceptable in the PCP clinic. Convenience and comfort with PCP and PCP clinic are reasons frequently cited for supporting PCP clinics offering abortion. Patient preferences about accessing abortion services at a specialty vs. PCP/ generalist continuity site are complex.

Conclusion: Overall abortion services in the PCP clinic setting appear acceptable to the majority of our respondents. Integrating early abortion services into the PCP clinic may be a way to increase access to service.
Abstract #24

Improving Pap Smear Follow-up Compliance in the Medical Group Practice: Bronx, New York
Pio Paunon, PhD, RN, FCCP, ABQAURP; Maureen Warner, RN, MS; Noel Brown, MD, MBA; Arthur Hopkins, MD; Ely Jacobs, MHA; Carolyn Zyloney (Boston Univ. Student)

Introduction: The number of women 18 and over who reported having a Pap smear in the past 3 years nationwide is 84%, and 85.1% for New York State. In 2000, the National Health Interview Survey reported 20% of women who have had Pap smears done reported having at least one abnormal Pap smear. There were 11,150 cervical cancer cases reported in the U.S. Women with abnormal results should return for a follow up colposcopy to further classify the abnormal conditions in their cervix and plan a treatment option. In order to achieve this, a protocol was developed in collaboration with the laboratory department to assure that each individual patient with abnormal Pap smear results is followed up throughout the 21 medical group practice sites. The objective of this study is therefore to investigate compliance rates related to the follow-up of abnormal Pap smear and describe the issues affecting colposcopy rates.

Literature Review: In 2006, 62% of women with all types of abnormal Papanicolaou smears returned for a colposcopy. Among women with more severe diagnosis, the colposcopy rate was only 60% for women with high-grade squamous intraepithelial lesions (HGSIL) and 75% among women with HGSIL-carcinoma in situ. The following are evidenced based recommendations related to improving compliance to Pap Smears and coloscopies: a) give Pap smear reminders to the patient and physician; b) set up a coordinated screening program; c) use letter reminders and preferably reminder telephone calls to encourage patients with abnormal Pap smears to seek follow-up care; d) give educational and emotional support following abnormal Pap smears; and, e) provide transportation incentives.

Results/Conclusions: During the 1st quarter of 2007, there were 280 abnormal Pap smears reported and 100% tracked of which 229 (81.8%) have had colposcopy. On the 2nd quarter of 2007, there were 256 abnormal Pap smears reported and 100% tracked of which 191 (74.6%) have had colposcopy. The results of the abnormal Paps follow-up system showed that each patient was tracked until all patients have had interventions accepted as per protocol. However, getting a 100% colpo rate seems to be the biggest challenge. There are 2 basic components required in order to be able to monitor every patient with an abnormal Pap smear and to provide them with appropriate care, namely: 1) a monitoring system to provide feedback to the care providers as to patients’ follow-up status, and 2) implement practice innovations that will help in improving the colpo rate.
Abstract #25

Maternity Care in New York City: Implications for Family Physician Education
Rebecca Williams, MD, MHPE

**Background:** Goal Maternity care is a core component of Family Medicine residency. All residents are required to complete a minimum number of obstetrics rotations, provide prenatal care to their patients in the office and deliver their patients. Despite this training emphasis on maternity care, most family physicians do not deliver babies after residency. The actual number of family physicians providing maternity care for patients in New York City is unknown. Whether family medicine residency training is sufficient and appropriate for the maternity care practices of family physicians in urban areas, like New York City, has not been explored. The goal of this survey was to assess the maternity care practices and learning needs of New York City Family Physicians.

**Methods:** We conducted an anonymous Internet survey in June & July 2007. Participants were family physicians practicing in New York City. There were no exclusion criteria. Electronic mail addresses were obtained from the New York State Academy of Family Physicians and using snowball methodology of known contacts. Participants received an electronic notice with a URL link to the survey. This study was classified EXEMPT by the Montefiore Medical Center Institutional Review Board.

**Results:** 135 physicians responded to the survey. Most were U.S. trained allopathic physicians. Practice settings were evenly mixed among residency-based practice, community health centers and private practice. Over half of respondents provide prenatal care and 11% deliver babies. Most physicians felt proficient at low-risk prenatal care. Nearly half would have enrolled in a Maternity Care Track had one been available in residency and 10-20% expressed retrospective interest in a Maternity Care Fellowship.

**Conclusions and Implications:** Family physicians training for urban practice will benefit from thorough training in maternity care, emphasizing prenatal care of both low and high-risk prenatal patients. Maternity care tracks and obstetrics fellowships should be available to enhance training for family medicine residents.
Abstract #26

Changing the Face of Reproductive Health: Discussions of Pregnancy and Contraception with Men
Emily Jackson, MD, Marji Gold, MD

**Context:** Women frequently cite the attitudes and practices of their partners as important factors that influence initiation and compliance with contraception, as well as decision-making surrounding pregnancy options. Despite the relational nature of sex, contraception, and pregnancy, data collection in these areas has traditionally focused on women, and understanding of the perceptions of men is lacking. Recent worldwide calls for addressing the reproductive needs of men, both in their own right and in relation to women, make the exploration of these topics with men especially pertinent.

**Objective:** To explore perceptions of pregnancy, pregnancy decision making, and contraception in a population of urban males of reproductive age.

**Design:** Qualitative study utilizing in depth interviews.

**Setting:** This study is being conducted in the Montefiore Medical Center Family Health Center, a federally funded community health center providing primary care in an ethnically diverse, urban, medically underserved neighborhood of the Bronx, New York.

Participants: English or Spanish interviews will be conducted with 30 men, aged 18-40, presenting to the waiting room of the Family Health Center.

**Participants:** Eligibility criteria include previously fathering a pregnancy, either carried to term or terminated.

**Expected Outcomes:** Identification of themes surrounding men’s current understanding of reproductive health, and their perceptions of their roles in pregnancy outcomes and contraception.

**Conclusions:** It is clear that men play a role in their own reproductive health and that of their partner. Information regarding their interpretation of that role, including contraception decision making and utilization, and pregnancy intention, will provide insight useful for more effective education and counseling of both men and women in these important topics. In impoverished urban areas, where rates of unintended pregnancy, abortion, and single motherhood exceed those of the nation, interventions developed from such data may prove even more valuable.
Abstract #27

Vaginal Douching Among Latinas: Practices and Meaning
M. Diane McKee, MD, MS, Maria Baquero, MPH, Adelyn Alvarez, MA, Matt Anderson, MD, MS & Alison Karasz, PhD

Context: Douching is common. It occurs in 53% of those with low socioeconomic status, 55% of Black women and 34% in Latinas. In some studies, 60-80% of high risk women and teens douche. The meaning of douching has mostly been studied in African American women.

Objectives: To investigate vaginal hygiene practices and the meaning associated with them for Latina women and guide development of an intervention to decrease douching among Latinas.

Setting: Two urban health centers and one school based health center

Design: Qualitative interview with those that were present for care, between 16 and 40 years of age, and indicated douching in past year on a brief screener.

Instrument: Explored perceptions of vaginal health and cleanliness, hygiene practices (including douching and non-douching, products and contexts), goals of douching, communication about douching and their reaction to the idea of stopping.

Results: Reported hygiene practices included frequent bathing, feminine cleansers, wipes, sprays and deodorant, suppositories and douching with US, Dominican and homemade products, and douching with alum for tightening of the vagina. Women report being taught about hygiene by female and beginning after coitarche. The following themes were identified: 1) the vagina was thought of as an especially sensitive, even vulnerable part of the body, 2) the inherent importance of cleanliness, 3) it was seen as important to remove residue from the vagina, and 4) beyond hygiene, cleanliness was identified with a sense of self. Two models emerged for why women douche. One was for cosmetic reasons, to feel clean (fresh), odor free, and attractive (including sexual attractiveness). The second was for infection control; they viewed cleanliness as a means to protect against infection or to treat infections. Most understood in general terms that there may be risks from “overdouching” such as pregnancy, “overdrying” the vagina, and interference with diagnosis and messing up your insides. When women were asked if they would ever stop douching various levels of commitment to douching were identified from being entrenched in the practice to being amenable to change.

Conclusions: Findings mirror studies conducted with African Americans to some degree. Women were fairly entrenched in the practice of douching; there was a familial transfer of information; and an importance of cleanliness. Some important differences included health care provider advice and products from the Dominican Republic. Social norms for douching were grounded in importance of cleanliness that women often valued over provider input. An intervention should include tailored messages respecting the importance placed on cleanliness and the close link to women’s sense of self. Clinicians should be aware of imported hygiene products, including use of medicines requiring a prescription in the US.
Abstract #28

**Abortion Training Improves Resident Gyn-Skills**
Linda Prine, MD, Ginger Gillespie, MD, Ilana Dzuba, MHS, Caitlin Shannon, MPH, Thomas Britton, MD, Mitchell D. Creinin, MD, Alisa Goldberg, MD, Robert Hanson, MD, Michelle Howe, MD, E. Steve Lichtenberg, MD, Michael Molaei, MD & Beverly Winikoff, MD, MPH

**Context:** Unintended pregnancy is a public health issue that has a ripple of negative consequences for our patients, their families and society.

**Objective:** To help patients plan their families, we have begun to offer more early abortion services in our residency practice and two attending practices. After integrating these services, we found that in addition to being able to offer skilled care in medication and early aspiration abortions, residents made significant progress in their skills in counseling and performing a variety of gynecology procedures.

**Methods:** Resident survey.

**Results and Conclusions:** A resident survey showed steady progress in resident comfort level with a range of gynecological skills from the PGY 1 to the 2 and finally the PGY 3 year. Some of the biggest improvements were seen in resident comfort with endometrial biopsy, IUD insertions, sonography, miscarriage management as well as contraceptive and pregnancy options counseling. One surprising outcome of the remodeled gynecology rotation is that the in-service exam scores of the Beth Israel residents for the gynecology have gone from being one of the lowest scoring areas to now being the highest scores for the PGY 3 year for two years in a row. This training also affected their plans for practice post graduation. Finally, training in early abortion care expanded their scope of practice so that pregnancy options counseling, pro-active contraception use, IUD insertions, medication abortions and, more rarely, early aspiration abortions are performed by many of them.
Abstract #29

Randomized Trial of Provider-Level Intervention Fails to Increase Internal Medicine Residents’ Prescribing of Contraceptives and Folate
M. Sobota, MD, JH Arnsten, MD, MPH, E Du, HV Kunins, MD, MPH

Background: Contraceptives and folate are highly effective in reducing reproductive risks. Yet interns are less likely to counsel reproductive aged women about contraception or folate than family physicians or obstetrician-gynecologists. Our goal was to determine whether a brief education session and clinical reminder intervention increased the proportion of internal medicine residents who prescribe contraceptives or folate to reproductive aged women.

Methods: We designed a randomized trial to assess the impact of the intervention on internal medicine residents’ prescribing of contraceptives and folate. Eligible participants included all Montefiore Medical Center categorical internal medicine residents on ambulatory rotations from November 2006-January 2007. Participants practiced at either a hospital- or community-based site. Reproductive aged patients at these sites are largely insured by New York State Medicaid, which pays for contraceptive and folate prescriptions. Participant randomization to the intervention or control condition was stratified by gender and clinic site. The intervention consisted of (1) a 10-minute education session conducted by a study investigator individually or in small groups, followed by (2) a one-month clinical reminder phase, during which medical assistants placed reproductive health reminder stickers on the charts of reproductive aged patients seen by intervention group residents. Control group residents received neither component. The main outcome was the proportion of participants who electronically prescribed contraceptives or folate for women ages 18-45 during a one-month period, six months after the intervention. Data were analyzed using Fisher’s exact test and binomial regression to adjust for unequal visits with reproductive aged women. We calculated that recruiting 27 participants to each group would yield 80% power to detect a 35% effect size.

Results: We enrolled 57 of 63 (90%) eligible residents. Participants randomized to the intervention (N=30) and control (N=27) groups were similar with respect to mean age (28.7 +/- 3.3 vs 28.1 +/- 2.1 years), gender (59% female) and practice site (63% hospital-based, 37% community-based). There were slightly more interns in the control group (62% vs 38%, p=.26). Intervention participants were one-third more likely to prescribe contraceptives or folate in the prior month than control group participants, but this difference was not significant (30% vs 22%, p=0.56). Folate was prescribed twice as frequently by intervention than control participants, although this difference was non-significant (25% vs 12.5%, p= 0.48). In a binomial regression analysis adjusted for visits, the intervention was not significantly associated with prescribing contraceptives or folate in the prior month (OR 1.7, 95% CI 0.71-4.1). The 8% effect size was less than the 35% anticipated, reducing the power to 5.6%.

Conclusions: Our brief education session followed by a one-month reminder sticker intervention did not significantly increase internal medicine residents’ prescribing of contraceptives or folate. Although non-significant, the finding that folate prescribing was twice as likely in the intervention compared to the control group suggests that this may be an easier practice to change than contraceptive prescribing. Future investigations are needed to understand internal medicine residents’ barriers to prescribing contraceptives and folate.
Abstract #30

Integrating Opioid Addiction Treatment with Buprenorphine in the Primary Care Setting
Chinazo Cunningham, MD

**Background:** Despite new opportunities to expand buprenorphine treatment in primary care, uptake has been slow. Physicians may question their ability to devote sufficient time to treating substance users and may be skeptical about the potential for buprenorphine treatment to be successful.

**Objective:** To describe a buprenorphine treatment program and treatment outcomes in an urban community health center.

**Design:** Three general internists and a pharmacist provided treatment (induction, stabilization, and maintenance) with buprenorphine/naloxone from November 2004 to January 2007.

**Patients:** 41 consecutive opioid-dependent patients.

**Measurements:** Retrospective chart reviews including data from standardized substance abuse histories, laboratory tests, and visits. The primary treatment outcome was 90-day retention in buprenorphine treatment.

**Results:** Patients’ average age was 46 years, and the majority were male (70.7%), Hispanic (58.8%) or black (31.7%), unemployed (57.5%), and used heroin prior to treatment (70.0%). Twenty-nine (70.7%) patients were retained in treatment at day 90. Compared to those not retained, retained patients were more likely to use street methadone (0% vs. 37.9%, p<0.05), and less likely to use opioid analgesics (54.6% vs. 20.7%, p<0.05) and alcohol (50.0% vs. 13.8%, p<0.05) prior to treatment. Of the 25 patients who had urine toxicology tests, 24% tested positive for opioids, and 64% tested positive for any drug.

**Conclusions:** Buprenorphine treatment for opioid dependence in an urban community health center resulted in a 90-day retention rate of 70.7%. Type of substance use prior to treatment appeared to be associated with retention. Among patients with urine toxicology tests, less than one-fourth had ongoing opioid use. These findings can help guide program development.
Abstract #31

Implementing Wound Healing Services in the Community Setting
Anna Flattau, MD MSc

**Background:** Non-healing wounds are prevalent in chronically ill and elderly patients. Racial and ethnic disparities have been documented in diabetic foot outcomes and may occur in other wound types. Integration of wound healing into primary care has been shown to dramatically reduce diabetic amputations. To address patients’ wound healing needs, we implemented dedicated wound sessions at a Federally Qualified Health Center (FQHC).

**Objectives:** To describe the early implementation of wound healing services in a FQHC.

**Setting:** Two half-day wound sessions were offered each week at the Family Health Center in the central Bronx. Services included sharp debridement, treatment of infections, topical therapies, and coordination of care with subspecialty services. Treatment of co-morbid medical issues was provided as needed. Most patients attended weekly or bimonthly visits. Services were publicized within the family medicine department and by word of mouth.

**Design:** A prospectively recorded patient registry was reviewed three months after services were implemented. We noted referral source, wound type, and need for management of medical disease.

**Results:** Ten patients were referred internally from the clinic (6 neuropathic foot and 4 leg ulcers). Six were referred from affiliated clinics (1 neuropathic foot, 3 leg ulcers, 1 pressure ulcer, 1 ischemic wound). Twelve of 16 patients required care of co-morbid medical conditions during one or more wound visit. In addition, 4 patients were referred who had no prior primary care provider (1 diabetic ulcer, 3 leg ulcers). Clinical sessions were nearly filled within the three-month implementation period despite limited publicity.

**Conclusions:** The need for chronic wound management is sufficient to support dedicated wound healing services at a Federally Qualified Health Center. Wound patients often have complex medical needs that require additional care during scheduled wound visits. Although pressure ulcers occur in community-dwelling patients, a clinic with limited disabled access does not easily identify these patients through internal or affiliated referral. Expansion of services to a site with improved disabled access and alternative referral sources may increase access for this population. Further research is needed to determine how wound services in a Federally Qualified Health Center can best improve clinical outcomes and reduce health care disparities.
Abstract #32

E-mail Consultation
Jean Burg, MD, Charles Nordin, MD

Context: Primary care clinicians (PCC) frequently need to consult with specialists regarding the care of their patients. This is usually done by arranging for the patient to be seen in the specialist’s office. In one Bronx NYC public hospital network, this system is encumbered with several problems:

- wait time for specialty appointments is several months for many specialties
- long waits result in treatment delays
- there is a high no-show rate for these appointments
- specialists’ findings and treatment plan/recommendations are frequently not available to the PCC

Objectives: Since many consultation questions may not require that the specialist see the patient, we would like to explore whether the use of email consultation is an acceptable alternative to in-office consultation for many clinical questions. We will study whether email consultation will result in:

- more prompt addressing of clinical questions, and therefore possibly improved clinical outcomes
- improved communication between specialist and PCC
- improved availability of specialty appointment slots for more complicated questions
- improved PCC, specialist and patient satisfaction

Setting: Practices involved include The Health Center at Tremont, The Health Center at Gun Hill, and The Health Center at Glebe

Quality Improvement Plan for studying benefits of email consultation:
We will develop guidelines for appropriate email consultation; define expectations of PCC and specialists; establish list of specialists willing to accept email consults; and establish efficient method of placing email communication in EMR.

Questions to be addressed in assessing quality improvement include:

- Do PCC questions get answered in a timelier manner?
- Do treatment changes occur in a timelier manner?
- Does this affect clinical outcomes (choose 2-3 measures)?
- Does availability of in-office specialty consults improve?
- What is level of satisfaction for patient, PCC and specialist?

Proposed Methods: The study design will include quality improvement with PDSAs, interviews with participants (PCCs & NBHN specialists), and data collection to be determined.

Potential results/benefits: Education of PCC via direct email communication with specialist, enhanced communication between PCC and specialist, timely addressing of clinical problems, freeing up of specialty appt slots for more complicated cases, improved PCC, specialist and patient satisfaction.

Potential barriers: HIPPA restrictions, unreimbursed time requirements for specialists and PCCs, impact on productivity.
Abstract #33

Medical Case-Finding for Recent Arrestees: Collaboration between a Primary Care Provider and a Public Defender in the South Bronx
Homer Venters, MD, Joe Deluca, MD, E. Drucker, PhD

**Context:** Residents of the South Bronx contend with high rates of criminal justice involvement which may interrupt access to primary care.

**Objectives:** 1) To create a collaboration between a large primary care clinic of Montefiore Medical Center and a nearby public defender agency, Bronx Defenders. 2) To assess the healthcare utilization of these clients. 3) To explore the opportunities for improving access to primary care among Bronx Defenders clients.

**Design:** Two years ago a collaboration was initiated between Bronx Defenders and a Montefiore Medical Center clinic. Bronx Defenders clients (all of whom had been arrested in Bronx County and required state-appointed legal representation) were given the opportunity to speak with a medical resident on-site for any reason during weekly office hours. These meetings were conducted in private and clients were given assistance in connecting with already established primary care or if desired, registered as patients at the Montefiore Medical clinic across the street for an initial visit with the resident. Information recorded from these client contacts included chief complaint, time to last primary care visit, medical history, immediate outcome (ie appointment scheduled) and final outcome (ie appointment kept).

**Results:** We now report a total of 89 client contacts over a 16 month period (preliminary results were reported one year ago from the first 27 clients). These contacts were made during 84 sessions with total physician time spent of approximately 220 hours. Chief complaints during the initial client contact included violent trauma, tooth pain, pelvic pain, release from jail without prescribed seizure, diabetes or HIV medicine, sexual assault, burns, suicidal plan, and chest pain. Of the 89 contacts, 33% (20/89) involved discussion only, 22% (20/89) involved assistance reconnecting a client with their prior medical care program, and 45% (40/89) resulted in new clinic appointments, of which 60% (24/40) were kept – similar to the kept appointment rate for the general clinic population. Women were more likely to keep their clinic appointment than men (76% vs. 44%) and averaged more recent contact with a non-emergency room physician than men (6.9 months vs. 9 months). The average time required for the resident to make a new clinic appointment by phone was 28 minutes. Of the 89 client contacts, 13 resulted in immediate action that had a positive outcome, such as emergency room visit, treatment of pelvic inflammatory disease, rape crisis counseling and having electric power turned back on (for medicine storage).

**Conclusions:** This collaboration has identified a novel method to provide primary care access to persons who have recently been arrested – an event that is often associated with disruption of health care. While other medical-legal collaborations have placed legal services within a medical clinic, this collaboration builds on the trust that clients place in their legal-aid lawyers and the advocacy orientation of the Bronx Defenders. Given the amount of on-site physician time required to make contact with individual clients (over 2 hours per client contacted); this model may prove more feasible with the use of health promoters or other non-MD persons on-site.
Abstract #34

Health Care Proxy Completion: Assessment and Intervention at an Outpatient Clinic
David Herszenson, MD, Victoria Gorski, MD

Context: Health Care Proxies are advanced directives that must be recognized by health care facilities by law. Most patients wait for their physicians to bring up the subject, yet most physicians cite time as a barrier.

Objective: To assess current practices regarding health care proxy discussion with patients among residents and attendings at 2 family medicine sites and to design interventions in order to increase the rate of health care proxy completion.

Design: Questionnaires completed by providers at both sites before and after the interventions. Interventions: Creation of a one page Health Care Proxy form, availability of HCP forms in each exam room, informational letter distributed to all providers about health care proxies and the project, and sticker prompts on physical exam forms reminding the provider to discuss the HCP with the patient.

Results/Conclusions:
- There is a disconnect between physician attitudes and actions.
- The intervention worked with a limited number of providers.
- The front desk staff may be the most effective place to initiate the conversation.
- Time is consistently cited as a barrier to discussing the HCP.
Abstract #35

Identifying Patient Panels at Family Medicine Teaching Practices
Bruce Soloway, MD, FAAFP, Jonathan Swartz, MD

Context: Every patient in a primary care practice should be assigned a unique primary care provider (PCP), providing a basis for continuity of care and provider accountability. When each provider knows the patients for whom he/she serves as PCP, the work of the practice can be defined and rationally divided, and each provider can receive individual feedback on aggregate demographics, processes and outcomes for the patients s/he treats. In teaching practices, with multiple part-time providers and frequent provider turnover, care is often shared between or among providers, and it is particularly difficult to assign PCPs and encourage continuity of care.

Objectives:
- To identify the physician who is the first source of primary care for each patient at two family medicine teaching sites.
- To create a “panel list” for each physician, naming all patients for whom the physician acts as primary care provider (PCP).
- To analyze the sizes of providers’ patient panels.

Practices involved: Montefiore Family Health Center (FHC) and Williamsbridge Family Practice (WB).

Study Design: Retrospective computer analysis of visit histories using Clinical Looking Glass (CLG).

Methods: At each practice, each patient seen in the past 18 months was assigned a “Visit-Based PCP” based on visit history and a “EMR PCP” based on the PCP assignment in the hospital’s electronic medical record. A “Panel Report” was created for each active provider listing 1) all patients for whom the provider was the “EMR PCP”, and 2) all patients who did not have an active “EMR PCP” but for whom the provider was the “Visit-Based PCP”. An “expected panel size” was calculated for each provider based on the total patient panel for the practice and the fractional FTE contributed by each provider to the total provider FTE for the practice (adjusted for expected resident productivity).

Measures: (Actual/expected) panel size and (actual-expected) panel size for each provider.

Results: At FHC, actual/expected panel size ranged from .02 to 1.93 and (actual-expected) panel size ranged from -428 to +389. At WB, actual/expected panel size ranged from .05 to 1.34, and (actual-expected) panel size ranged from -401 to +164. The most underpaneled providers were new providers to the practice; the most overpaneled providers were those who had substantially reduced their practice hours due to added academic or administrative responsibilities.

Conclusions: Meaningful patient panels can be constructed from retrospective visit histories in the hospital database. Many providers are significantly over- or underpaneled for their respective practice hours. Patients are likely to have difficulty getting appointments with overpaneled providers, and underpaneled providers are unlikely to achieve optimal productivity. Panel lists may facilitate rational realignment of patients to match panel sizes to provider capacity, improving both access and productivity.
Abstract #36

Developing Resident Competence in Practice-based Learning and Improvement via Experiential Learning on Continuous Quality Improvement Teams
Victoria Gorski, MD, FAAFM, Alice Fornari, EdD, RD

Context: Developing resident competency through continuous quality improvement projects in urban underserved communities is important for improving patient care.

Objectives: To provide residents an opportunity to learn and apply CQI knowledge and skills in teams at continuity practice sites. To build on established QI efforts through the HRSA Disparities Collaborative (Diabetes), NYCDOHMH Diabetes Collaborative, Montefiore Excellence Clinical Focus on Diabetes, and Bronx BREATHE.

Setting and Participants: Montefiore Medical Center Family Medicine Residency of the Residency Program in Social Medicine, which has a focus on urban underserved communities. Includes thirty residents in two Montefiore Medical Group Practices: 1) Williamsbridge Family Practice (WBFP), which serves a working class Afro-Caribbean neighborhood, and 2) The Family Health Center (FHC), which is a Title 330 Community Health Center.

Quality Improvement Implementation:
- In year one the project was introduced to faculty and residents. There were faculty development sessions, a guest seminar and negotiations with clinical sites for time, space, and staff.
- In year two the project included monthly meetings at continuity practices, discussion of project options, creation of aim statements, practice in root cause analysis, distribution of team member roles, and practice in execution of PDSA cycles. Two teams worked on smoking cessation, one team worked on LDL reduction in diabetes, and one team worked on physical activity promotion in diabetes.
- In year three all teams are continuing with the same themes, however they are more focused. We have chosen defined and easily measurable processes and outcomes. Further faculty development is scheduled and there will be an implementation of a new resident evaluation tool.

Evaluation Measures: Evaluation had two components: 1) expert evaluation of team presentations at a special conference by the Director of Quality Improvement MMC, the Director of the Center for Evaluation of Health Programs, the MMG II Medical Director and the Vice-Chair of Clinical and Educational Affairs for DFSM, and 2) resident self-evaluation and evaluation of the teaching program.

Results: The expert assessment showed that teams operated at low levels of change (expert scores 1 & 2). Resident assessment showed that the skills and knowledge attained were present, but limited. The residents agreed on a need for increased faculty knowledge and facilitation skills.

Conclusions: Systematic participation by residents and faculty in CQI is a complex endeavor. Implementation of consistent evaluation tools and feedback to participants is critical to success. Tying resident projects to larger health system initiatives is a useful strategy.
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