



2018 Southern California Regional Dissemination, Implementation & Improvement Science Symposium

Creating Learning Health and Population Health Systems

Thursday, June 28, 2018, 8:00am- 4:00pm
The California Endowment
#SoCalDII18



UC San Diego
Altman Clinical and Translational
Research Institute

USC Gehr Family Center
for Health Systems Science
Keck Medicine of USC



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UNIVERSITY OF CALIFORNIA, IRVINE



The mission of the UCLA CTSI is to create a borderless clinical and translational research institute that brings UCLA resources and innovations to bear on the greatest health needs of Los Angeles. The Dissemination, Implementation and Improvement Science Initiative is a component of the UCLA CTSI Community Engagement and Research and Population Health Programs.



Steven M. Dubinett, MD
Director



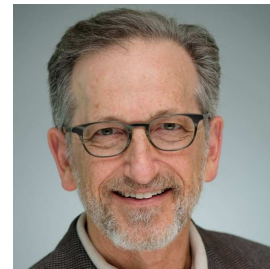
The University of Southern California CTSI helps accelerate scientific discoveries and their application in real-life settings to address the specific health needs of urban and diverse populations and improve human health, by helping researchers obtain the education, resources and collaborations necessary to translate discoveries into practice.



Thomas A. Buchanan, MD
Director



UC San Diego Altman Clinical and Translational Research Institute (ACTRI) helps researchers obtain education, resources, and collaborations necessary to translate scientific discoveries into improved human health and provides research resources, training, and collaboration opportunities for ACTRI scientists, health care providers, and the community. The Dissemination, Implementation and Improvement Science Initiative is part of the Community Engagement Unit at UC San Diego ACTRI.



Gary S. Firestein, MD
Director



The mission of the Gehr Family Center for Health Systems Science is to accelerate the adoption of high-value healthcare in Los Angeles and nationwide through science, evidence based advocacy and education.



Michael Hochman, MD, MPH
Director



The mission of the Division of Health Services and Implementation Science of the Department of Research & Evaluation is to initiate and conduct high-quality public-sector health services, epidemiologic, behavioral, and clinical research that has a demonstrable positive impact on the health and well-being of Kaiser Permanente Southern California members and the general population.



Michael K. Gould, MD, MS
Director



The University of California, Irvine's Institute for Clinical and Translational Science (ICTS) improves health and healthcare by catalyzing translational research across the spectrum and by advancing the science of translation. Our history of successful community-university partnerships provides a virtual laboratory for advancing best practices in community-engaged translational research and accelerating the movement of new basic science discoveries to healthcare practice.



Dan Cooper, MD
Director

Welcome

On behalf of the UCLA Clinical Translational Science Institute, the Southern California Clinical and Translational Science Institute, UC San Diego Altman Clinical and Translational Research Institute, USC Gehr Family Center for Health Systems Science, Kaiser Permanente Southern California, UC Irvine Institute for Clinical and Translational Science and the Veterans Administration Greater Los Angeles Healthcare System, we are pleased to welcome you to the Fourth Annual Southern California Regional Dissemination, Implementation and Improvement Science Symposium.

This meeting reflects continued growth in the importance of Dissemination, Implementation and Improvement (DII) Science in our nation's health policy, education and research agendas – and the significant leadership and capability in DII Science shown by each of our institutions and regional partners. The sessions included in the symposium illustrate the breadth, depth and diversity of DII Science expertise and activity throughout Southern California, and the value of this activity in improving health and quality of life throughout the region.

Today's symposium is an important component of our shared commitment to focusing investigators and practitioners on what health systems seek in feasible solutions; increasing familiarity with suitable methods for developing and introducing improvements in real-world delivery systems; sparking future collaborations; and identifying ways that we can work together to strengthen our local capabilities in learning methods that support health systems.

We intend for today's symposium to foster more and better partnered research that improves health systems performance and outcomes. We also seek to build our professional network and a shared vision of success. As with previous symposia, we hope to see continued growth and new collaborations and initiatives emerge from the day's activities. We look forward to the results of this symposium and to the new energy, creativity and commitments that follow. We extend our thanks to the speakers, presenters, and participants involved in the event.

Agenda

07:15-08:00 Registration and Poster Check in

08:00-08:15

Yosemite

Welcome

Steven Dubinett, MD – Director, UCLA Clinical and Translational Science Institute
Tom Buchanan, MD – Director, Southern California Clinical and Translational Science Institute

08:15-08:35

Yosemite

Call to Action: Perspectives from Health Care and Population Health

Anish Mahajan, MD, MS, MPH - Chief Medical Officer, Harbor-UCLA Medical Center
Tony Kuo, MD, MSHS – Director of Senior Health and Chronic Disease & Injury Prevention,
Los Angeles County Department of Public Health

08:35-08:45

Yosemite

Introduction to the Symposium

Brian Mittman, PhD – Kaiser Permanente Southern California & UCLA Clinical and Translational Science Institute

08:45-09:15

Yosemite

Learning in Complex Systems

Lloyd Provost, MS – Senior Fellow and Improvement Advisor, Institute for Healthcare Improvement

09:15-10:00

Yosemite

Featured Projects:

Engineering A Better System for Comorbid Depression Care Management among Low-Income Type 2 Diabetes Patients

Shinyi Wu, PhD – University of Southern California

Implementation of Childbirth-Specific Patient-Reported Outcomes Measures in the Hospital Setting

Kim Gregory, MD – Cedars-Sinai Medical Center

Coordinating Care in VA: Supporting Transitions in Care to Foster Population Health

David Ganz, MD, PhD – VA Greater Los Angeles Healthcare System

Agenda

10:00-10:15

Break

10:15-11:30

Workshops:

Yosemite

A Framework to Create System Alignment in Learning Health Systems

Reshma Gupta, MD – UCLA Health System

Yosemite

Care Connections Program: Implementing a Community-Academic Partnership

Clemens Hong, MD – Los Angeles County Department of Health Services

Yosemite

Population Approach to Managing Hypertension

Tony Kuo, MD – Los Angeles County Department of Public Health

Sequoia

Genomic Medicine and Implementation Science

Maren Scheuner, MD – VA Greater Los Angeles Healthcare System
Catherine Chanfreau, PhD – VA Greater Los Angeles Healthcare System
Lawrence Kushi, ScD – Kaiser Permanente Northern California

Catalina

How to Write and Publish Implementation and Improvement Science

Greg Aarons, PhD – University of California San Diego
Lloyd Provost, MS – Institute for Healthcare Improvement

Cabrillo

The E-SCOPE Initiative: A Strategic Approach to Identify and Accelerate Implementation of Evidence-Based Best Practices

Shayna Henry, PhD ; Joel Whittaker, MPH ; Yasmina Mohan, MPH ; Joanne Schottinger, MD – Kaiser Permanente Southern California

Mojave

Capacity Building in Dissemination, Implementation and Improvement Science

Miriam Bender, PhD – University of California Irvine
Margaret Handley, PhD – University of California San Francisco
Lauren Brookman-Fraze, PhD – University of California San Diego

Agenda

11:30-12:30

Yosemite,
Joshua Tree,
and Cabrillo

Poster Session

- Optional poster tours: See attached list of poster tours. Sign up in lobby.

11:30-12:00 Guided Poster Tour 1

12:00-12:30 Guided Poster Tour 2

12:00-01:00

Lunch

01:00-01:45

Yosemite

Panel: Embedded Research Programs in Health Systems

Moderator: Tracy Lieu, MD – Director, Division of Research Kaiser Permanente Northern California

Reshma Gupta, MD – UCLA Health System

Michael Gould, MD – Kaiser Permanente Southern California

Anne Escaron, PhD – AltaMed

Anish Mahajan, MD – Harbor-UCLA Medical Center

01:45-03:00

Strategy Discussion Forums

Concurrent forums intended to stimulate conversation and brainstorming in small groups around opportunities for regional collaboration and increasing applied research in the area of dissemination implementation and improvement science for a specific topic.

- See attached list of discussion topics and room assignments.
Suggestions for ad hoc discussion topics can sign up in lobby.
-

03:00-03:30

Yosemite

Symposium Reflections & Poster Awards

Michael Gould, MD – Director, Kaiser Permanente Southern California,
Division of Health Services Research and Implementation Science

Speakers

Anish Mahajan, MD, MS, MPH

Dr. Mahajan is the Chief Medical Officer at Harbor-UCLA Medical Center and Associate Dean of the David Geffen School of Medicine at UCLA. From 2012 through mid-2016, he was Director of System Planning, Improvement, & Data Analytics for the Los Angeles County Department of Health Services, where he helped lead organizational transformation under the Affordable Care Act and oversaw multiple system-wide units including the Office of Planning & Data Analytics.

Lloyd Provost, MS

Mr. Provost helps individuals and organizations in a range of industries learn the science of improvement. Through API's partnership with the Institute of Healthcare Improvement (IHI), Lloyd is a senior fellow and serves as an improvement advisor supporting IHI's innovation and improvement programs. He serves as faculty for IHI's Improvement Advisor Professional Development Program and supports IHI's programs in developing countries. He co-authored key texts in improvement science including Quality Improvement Through Planned Experimentation, The Health Care Data Guide, and The Improvement Guide.

David A. Ganz, MD, PhD

Dr. Ganz is a practicing internist and geriatrician, and serves as Associate Director of the VA Greater Los Angeles HSR&D Center for the Study of Healthcare Innovation, Implementation and Policy (CSHIIP). He is also Associate Professor of Medicine at UCLA, and Adjunct Natural Scientist at RAND.

Reshma Gupta, MD, MSHPM

Dr. Gupta is an internist and the Medical Director for Quality Improvement at UCLA leading over 70 clinicians in quality and value improvement initiatives across all departments. She works as an expert advisor with the Center for Medicare and Medicaid Innovations and as a Director with Costs of Care, Inc.

Anne Escaron, PhD

Dr. Escaron oversees research and implementation initiatives to improve healthcare service delivery to underserved communities in Southern California. She develops patient-centered care delivery in community health centers.

Tony Kuo, MD, MSHS

Dr. Kuo directs the Division of Chronic Disease and Injury Prevention in the Los Angeles County Department of Public Health. He also serves as the Director of the Office of Senior Health. He is boarded in Family Medicine and has joint appointments in the UCLA Departments of Epidemiology and Family Medicine. Dr. Kuo co-leads the UCLA CTSI's Population Health Program.

Shinyi Wu, PhD

Dr. Wu is an Associate Professor of Social Work and Industrial and Systems Engineering at USC. Her research has focused on enhancing quality of health systems and reducing health disparities.

Kimberly Gregory, MD, MPH

Dr. Gregory has a joint appointment at Cedars-Sinai, UCLA Schools of Medicine and Public Health, with a 30-year history of research in maternal and child health, maternal mortality, morbidity, healthcare quality, and childbirth patient reported outcomes.

Tracy Lieu, MD, MPH

Dr. Lieu is the Director of the Division of Research, Kaiser Permanente Northern California. She leads a group of 600 people who conduct studies in clinical effectiveness, delivery science, and epidemiology to enhance the health of Kaiser Permanente members and society at large.

Michael K. Gould, MD, MS

Dr. Gould is a pulmonologist and health services researcher with longstanding interest in the care of patients with respiratory disease, venous thromboembolism and lung cancer. He currently serves as Director for Health Services Research and Implementation Science at Kaiser Permanente Southern California, where he conducts both externally-funded and operationally-focused research.

Abstracts- Work in Progress

1

Bridging the Gap between In-hospital Acute Care and Outpatient Recovery with a Public Hospital-Community Partnership

Castelan M, Morrison J, & Biswas S

Background and Aims. Hospitalizations from traumatic injuries including car accidents, gunshot wounds, and falls are often a patient's first encounter with the healthcare system. These incidents are devastating for individuals and their caregivers, as they struggle to recover physically, emotionally, and financially from serious injuries while navigating an unfamiliar and unforgiving healthcare landscape. However, such hospitalizations also represent an opportunity – to guide patients and families into long lasting connections with healthcare providers and long-term healthy living.

Methods. We describe a novel ongoing partnership between Los Angeles County –University of Southern California Hospital (LAC-USC), a safety-net hospital serving the people of Los Angeles, and The Wellness Center, a nonprofit provider of multidisciplinary health and wellness support services. During this pilot study, inpatient trauma patients and families are integrated into outpatient community support services while they are still hospitalized, starting with a visit from Wellness Center Navigators. Navigators provide essential individualized guidance on health insurance, legal issues, primary care, nutrition, and fitness for patients. These services are continued after the patient is discharged with regular followup. In this way, we hope to integrate trauma patients into the longer term health and wellness of their communities.

Results. After 6 months, 48 trauma patients and families have been contacted and connected with Wellness Center services. The majority of patients were aided in obtaining health insurance, as well as transportation services to medical appointments, while others were connected with primary care physicians, or obtained legal counseling services. In addition, families were counseled in nutrition and healthful lifestyle choices.

Conclusion. Inpatient hospitalizations represent an opportunity to integrate patients into community-based health and wellness services, which may improve long-term outcomes. Hospital-Community partnerships are a viable and potentially powerful means to accomplish this.

2

Strategies for Implementing a Sustainable Peer-Led Program in Senior Centers

Takemoto M, Bolling K, Lewars B, Crist K, & Kerr J

Background. Less than 3% of older adults meet physical activity (PA) guidelines. The Peer Empowerment Program for PA (PEP4PA) is a peer-led multi-level PA program in senior centers.

Methods. PEP4PA is a cluster RCT, hybrid type 2 effectiveness-implementation study with an 18-month re-randomization. PEP4PA immediately transitions intervention delivery from UCSD research staff to peer health coaches (PHCs) and center staff from within senior centers. Prior to program launch, PHCs and a center staff member complete a 16-hour training course and certification to lead the program and build a sustainment plan. To promote success, the intervention dose ensures PHCs have capacity to deliver the components by encouraging in-person counseling, using color coding to identify goal setting, and working with participants who are most in need. To assess intervention fidelity, PHCs track intervention delivery including attendance, participant step counts and progress towards goals on an online tablet in real-time. PEP4PA is a pragmatic trial and models the Plan-Do-Study-Act framework to continue to improve implementation during intervention rollout based on results from both the tablet and process measures administered every 6-months.

Findings. Currently there are 4 intervention sites (out of 6 total to recruit) enrolled at various stages. The first site was re-randomized to no support in April and will conclude the study in October. The second site reaches the 18-month re-randomization in September while the newest sites just completed 12-months and 5-months in the program. Based on results from the tablet, attendance drops off at around 6-months going from around 75% to around 60% where it remains stable. Variability in participants meeting step goals is high across sites ranging from 65% to 85% and could be due to a number of factors such as PHC turnover or burnout. Results from the tablet, presented at team meetings, encourage PHCs to work with participants not reaching goals and monitor program progress.

Implications for D&I Research. Continuing to improve intervention delivery during the course of the program has led to a more robust intervention with a high likelihood of sustainment. To improve intervention fidelity, we include spot-checking by UCSD staff on data from the tablets to ensure continued feedback to PHCs regarding program implementation.

3 Utilization of Patient Education Videos Prescribed through a Patient Portal

Sampat A, Woo H, Aysola R, Zeidler M, Fung CH

Background. Supplementary education in sleep medicine improves patients' understanding of health conditions and improves adherence to therapy. UCLA Health System offers patient education videos (from a third-party vendor) about sleep conditions. Providers can prescribe the videos, which are part of the electronic sleep order set. Patients access a video link through the electronic health record patient portal. As an initial step of a quality improvement project, we evaluated whether our patients are accessing the videos and whether subgroups (e.g., older patients) have lower utilization of the videos.

Methods. We analyzed data collected as part of routine care, on utilization of sleep-related videos among patients at UCLA between 2016 and 2017. Topics included overviews of OSA, sleep study, continuous positive airway pressure (CPAP), and insomnia. Prescribing rates, rates of access, and time to access (in days) were measured. Differences in video access and time to access based on age (≥ 65 vs. < 65 , ≥ 80 vs. < 80) and video type were assessed using chi-square or t-tests.

Results. From 2016-2017, 2,156 videos were prescribed, and 20% of videos were accessed. Rates of prescribing by age group were: 0-17 (<1%), 18-34 (11%), 35-49 (23%), 50-64 (30%), 65-79 (31%), and 80+ (5%). OSA (33%) and CPAP (28%) videos were more commonly prescribed than insomnia (19%) or sleep study (21%) videos. There was no difference in access between patients ≥ 65 versus < 65 years ($p=.52$). Patients ≥ 80 years had lower rates of access than those < 80 years, but the differences did not reach statistical significance (12.8% vs. 20.5%; $p=.05$). There was no difference in access based on video type ($p=0.25$). Patients ≥ 80 years took significantly longer to start viewing the videos (46 vs. 22 days, $p=0.01$).

Conclusion. Most patients did not access the prescribed video. Older patients (80+) took longer to start viewing videos. These results support developing quality improvement interventions to support greater and more timely use of the videos, especially in the advanced age group.

4 Strategy for Implementing the Diabetes Prevention Program among Employees at a Federally Qualified Health Center

Escaron A, Chung J, Velasco-Gonzales O, Solomon K, Tibavinsky L, Duncan W, Rink V, Torres Mosst J, Shapiro I, & Hochman M

Background and Aims. Roughly 90 million U.S. adults are prediabetic, and 9 out of 10 are unaware of their condition. Without intervention, 15-30% of people with prediabetes will develop Type 2 diabetes within the next 5 years. Given the high medical costs associated with diabetes and the public health imperative to address this high prevalence condition, the federally qualified health center where we work --- AltaMed Health Services piloted an onsite DPP for employees at no charge in January 2017. This CDC recognized lifestyle change program was implemented by a community-based DPP provider with funding from the local public health department. Our primary aim is to describe our implementation strategy for employee DPP participation and impact on partnerships, attendance, and weight loss.

Methods. In preparation for the pilot, a subset of AltaMed employees based at the corporate headquarters were surveyed via SurveyMonkey in the summer of 2016 to assess demographics and interest in DPP (7 items) and risk for prediabetes (7 item CDC screener).

Results. Of employees who responded to the survey ($n = 282$), 40% were at high risk for prediabetes; of those, 74% were interested in learning more about DPP. After this survey, community partners facilitated an employee information session in November 2016, recruited participants and started DPP January 2017 with 13 participants. At 6 months, 12 participants (92%) averaged 15 sessions each and achieved on average $\geq 5\%$ weight loss. At 12 months, no participants were attending.

Conclusions. At AltaMed, we piloted the DPP among 12 volunteer employees. After 6 months, participants had achieved on average $\geq 5\%$ weight loss suggesting engagement during the first half of the program, however, all had dropped out of the program by the 12 month mark. Such attrition is common with lifestyle programs like the DPP, however, worksite interventions like this one present particular barriers, such as workload, scheduling changes, and confidentiality concerns. Efforts are underway to implement strategies to address these worksite barriers and incorporate sustainability through renewed collaboration with partners including employee health insurance plans covering DPP to offer a 2nd round of onsite DPP to employees.

5 GLA TARGET PROGRAM: Large-Scale Shared Medical Appointments

Braddock Watson A, Altman L, & Levitan L

In June 2012, the Office of Patient Centered Care called for unfencing proposals to eliminate restrictions impeding patient care. At the time, our Lead Physician, a health psychologist, and health coach team at the Los Angeles Ambulatory Care Center (LAACC) expressed interest in conducting a shared medical appointment. In addition, the Health Promotion and Disease Prevention and Office of Patient Center Care joined in the creation and support of TARGET Diabetes.

The program is a large-scale shared medical appointment (SMA) for patients with A1cs > 6. It is designed to offer a one-stop shop for patients with pre-diabetes and diabetes, providing them education and multidisciplinary care as well as linking them to VA resources. The event involves Primary Care Providers, Health Promotion and Disease Prevention, Patient Education, Psychology, Health Coaching, Nutrition, Diabetes Education, Social Work, Pharmacy, Home Tele-Health, My HealthVet, Optometry, and Podiatry. Patients with a diagnosis of diabetes, pre-diabetes and/or an A1c > 6 are identified from the Primary Care Almanac; they are invited via an audio care call, provider referral or walk-in. The event was so successful that we expanded to other topics. We developed a TARGET Tobacco program inviting anyone with a diagnosis as a smoker; at the event they are connected to the in-person, telephone-based and computer-based resources for smoking cessation. Same day receipt of nicotine replacement therapies is available. TARGET Whole Health was developed to provide personalized, proactive, patient-driven care equipping Veterans to take charge of their health-care and well-being. We focus on meeting the patient where s/he is, goal setting and connecting the Veteran to available VA resources. A sample of patients with the appropriate diagnosis based on the event are invited to attend. TARGET programs are offered quarterly so that each month there is an event. Attendance averages around 50 Veterans per event. Qualitatively, patients have expressed great satisfaction with the events and sign up for the resources made available to them. Staff have been pleased, and more disciplines want to get involved. One encounter and note is created for the event, thus ensuring all presenters receive workload credit. We hope to expand the TARGET Program further to include more topics and be offered at more sites.

6 Implementation of a Maternity-Centered Medical Home: Population Health Management and Risk Stratification in Prenatal Care Reduces Preterm Births for African American Women in Los Angeles County

Scibetta E, Greenwell L, Moini M, Jackson AM, Pietersz D, Canto- Young C, Trang C, & Saleeby E

Background and Aims. Preterm birth (PTB) is the leading cause of infant mortality. African American (AA) women are 48% more likely to have a PTB than non-Hispanic whites and experience myriad social stressors that contribute to PTB risk including: limited prenatal care (PNC), substance use, intimate partner violence and mental illness. MAMA'S Neighborhood (MAMA's), LA County Department of Health Services' (LAC DHS) organizes PNC into a medical home model of wrap-around services. MAMA's implemented risk assessments at prenatal intake in the domains of behavioral health, substance use, housing/food insecurity and medical risk; and then stratified risk groups to direct levels of care management and wrap-around services to address social and biomedical risks associated with PTB. This study evaluates the impact of MAMA's on PTB amongst women with continuity of care and delivery within LAC DHS before and after the initiation of MAMA's services. **Methods.** This is a retrospective cohort study, using administrative datasets to compare the outcome of PTB, defined by ICD-9 coding, for women delivering within LAC DHS during two time periods: 1) women receiving PNC prior to MAMA's (2013-2014) and 2) MAMA's participants after full implementation (2015-2016). PNC continuity was defined if ≥ 2 visits occurred. Women with multiple births were excluded. Multivariate logistic regression was performed and risk factors were controlled for including: medical comorbidities, maternal age and history of PTB.

Results. 1021 women were included in historic controls and 448 women in the intervention group. Intervention group was limited to second and third phases of implementation to assess treatment impact. PTB among AA women dropped from 20% in historic controls to 9% in MAMA's program. Regression analysis reveals that PTB among AA women in MAMA's was reduced when compared to historic controls with an odds ratio of 0.27 (CI 0.078-0.909), $p < 0.02$.

Conclusions. MAMA's made a clinically and statistically significant impact on PTB outcomes for AA women, a critical step in addressing the current health equity gap. MAMA's represents a promising value-based strategy that leverages multidisciplinary collaborative care with existing social services in the safety net to reduce poor birth outcomes for women.

7

Facilitating Cardiovascular Risk Reduction in Women Veterans: How Does it Get Done and Where Do Providers Get Stuck?

Bean-Mayberry B, Moreau JZ, Dyer K, Brunner J, Chanfreau C, Schweizer CA, Finley E, Hamilton A, & Farmer MM

Background & Aims. Cardiovascular disease (CVD) is the number one cause of death in American women, and all adult women are potentially at risk for CVD. While CVD awareness has increased, many women still demonstrate limited understanding of the imminent risks of CVD-associated morbidity and mortality. This project sought to understand provider and clinical staff approaches and barriers to CVD risk-screening and risk-reduction discussions and care for women Veterans in the Veterans Health Administration (VA).

Methods. We conducted semi-structured qualitative interviews with field-based key informants (primary care providers, medical directors/leads, nurses, and other staff directly involved in women's care delivery) at two VA comprehensive women's health centers. Transcripts were summarized in a template to capture key points. Themes were identified and iteratively revised via a collaborative decision-making process utilizing matrices to compare content across interviews.

Results. Key informants (n=15) were generally comfortable discussing traditional CVD risk factors and lifestyle changes (e.g. diet and exercise) with women patients, and reported having these conversations in clinic very frequently. They reported assessing patient activation/motivation to change by directly asking the patient, listening to concerns, and monitoring body language, but their confidence in doing these varied. Barriers to discussing CVD risk in primary care visits included competing demands of comorbid conditions (e.g. mental health and chronic pain), and overall patient complexity. Social factors were perceived as dominant barriers to patient lifestyle changes, including busyness, caregiving responsibilities, and limited finances. Key informants' strategies to address these barriers with their patients included tailoring the approach to the individual patient (meeting the patient "where she is at"); aligning discussions with patient goals; and offering small incremental steps, options for support, and repeated positive reinforcement.

Conclusions. VA clinical providers and staff conveyed a range of barriers to prioritizing CV risk reduction and shared their strategies for overcoming barriers. Understanding the barriers and the diversity of solutions will enable better-informed interventions to facilitate CV risk reduction. Innovations that assist with overcoming barriers will move patients forward with specific lifestyle changes and/or treatment goals that optimize care and ultimately encourage heart health.

8

Development and Implementation of a Novel Medicaid Enrollment Process for Correctional Health Settings.

Hsieh D

Background and Aims. The Los Angeles County Jail system is the largest in the world housing many of the county's most vulnerable residents, including those with mental health, substance abuse, and chronic medical conditions. Re-entry is a vulnerable time for these individuals, with an estimated risk of death 12.7 times greater than that of the general population in the weeks following release. Access to medical care and insurance are key pillars to health stabilization during this time. The Whole Person Care re-entry pilot at the Los Angeles County jails seeks to develop a process for Medicaid enrollment to ensure immediate Medicaid eligibility upon release so that these vulnerable individuals can access care.

Methods. This work takes place in the Los Angeles County jails and focuses on high risk individuals ≥ 18 years old. Eligible participants are identified and enrolled during the jail medical intake process by medical case workers. Participants are screened for and enrolled in Medi-Cal through a process developed and refined collaboratively by Department of Health Services Los Angeles and Los Angeles Sheriff Department through process improvement (PDSA cycle). At the time of release, communication between DHS and Department of Social Services triggers Medi-Cal activation allowing for continuity of care and close outpatient primary care follow-up.

Results. At project onset there was no mechanisms of active Medi-Cal enrollment in the of the Los Angeles county jail system. Through our innovate workflow we were able to enroll approximately 95% of our pilot cohort in Medi-Cal. Grounded in this process we have developed mechanisms essential for safe transitions of care including primary care scheduling, acquisition of durable medical equipment, specialty care coordination, and essential discharge medication prescriptions. We anticipate these processes will have a demonstrable impact in improving the health of our reentry patients.

Conclusions. Through our experience we conclude it is possible to create systems that ensure Medi-Cal enrollment of incarcerated populations by the time of release. While complex, the process can be simplified and refined through the PDSA process. Critical to the innovation was inter-agency collaboration and development of mechanisms to anticipate release dates.

9

www.HealthDat.Org: Facilitating Research Partnerships, Building Capacity of Community Based Organizations, and Encouraging Community Engagement

McDaniels-Davidson C, Penn T, Lindsay S, Seidman RL, & Taras H

Background and Aims. Often, the results of academic research do not reach the intended audience; local communities and the organizations within them may be unaware of and/or unable to effectively utilize research findings to promote health. The Dissemination, Implementation and Improvement (DII) Science movement grew out of a need to address this problem. San Diego County is geographically and demographically unique, bordering the Pacific Ocean and Mexico. Across and within neighborhoods, the population varies greatly in SES, acculturation, and languages spoken. DII researchers must understand and embrace these unique neighborhood-level characteristics in order to effectively recruit from, collaborate with, and intervene in communities. This is possible only if researchers have access to local data, community-based organizations and leaders, and information about existing efforts to improve neighborhood health. Community organizers need this information and to identify local academics able to collaborate to implement relevant research. HealthDAT San Diego is a free, user-friendly online platform that strives to address this need by providing 1) visual neighborhood-level health indicators, demographics, behaviors, and social determinants of health; 2) descriptions of best practices to address health issues; 3) neighborhood resources that address these issues; 4) links to community-engaged academics interested in collaborating; and 5) links to existing local collaboratives.

Methods. A multidisciplinary team from the University of California, San Diego and San Diego State University was formed to create the HealthDAT data platform. The Executive Team drove the overall vision by working with community partners to identify relevant indicators and data sources; define best practice criteria; define, locate and categorize community resources; and solicit academics willing to collaborate. Student interns and staff extracted data from public websites and imported the data into common templates for upload to the site. Currently, HealthDAT San Diego is being pilot tested with academic and community audiences. Feedback gathered during this process will inform the final public version of the platform.

Conclusions. The ultimate goal of HealthDAT San Diego is to be a tool for the implementation of precision public health through facilitating research partnerships, building the capacity of community-based organizations, and encouraging community engagement. A structured evaluation will ensure these goals are attained.

10

Implementing Lifestyle Redesign Occupational Therapy in a Safety-Net Patient Centered Medical Home

Pyatak E, King M, Diaz J, Vigen C, Schepens-Niemiec S, Jordan K, Blanchard J, Salazar E, Banerjee J, & Shukla J

Background and Aims. The Los Angeles County Department of Health Services (LAC-DHS) has prioritized comprehensive care for patients with poorly controlled diabetes as a designated area for improvement, and lifestyle management occupational therapy (OT) interventions such as Lifestyle Redesign (LR) in primary care have shown promise in improving diabetes outcomes. We are examining how LR-based OT (LR-OT) can be integrated into a primary care clinic within LAC-DHS, with an initial focus on diabetes. The study has two co-primary aims: 1) Evaluate the impact of LR-OT on patients' health and quality of life; and 2) Evaluate the process of integrating LR-OT in an interdisciplinary primary care team.

Methods. This hybrid implementation-effectiveness study incorporates formative data on referral patterns, provider communication, and patient enrollment and retention, and summative data on clinical and psychosocial outcomes. Adult patients with HbA1c >9.0% referred by clinicians to LR-OT are randomly assigned to be offered LR-OT or to serve as a no-contact comparison group. Patients randomized to LR-OT are seen for approximately eight biweekly one-hour sessions and complete pre-post measures of HbA1c, psychosocial outcomes and patient satisfaction. Data sources include medical chart review, participant observation, interviews, and self-report data from LR-OT participants.

Results. As of 5/1/2018, 141 eligible patients were referred to the program. Among the 73 patients randomized to LR-OT, 43 (59%) enrolled, 5 (7%) declined, and 25 (34%) were lost to follow-up. To date, 17 patients have completed the program, with mean positive changes in HbA1c (-1.65% decrease), healthy eating (+1.3 days/week), checking blood sugar (+2.1 days/week), and medication adherence (+18.3; 0-100 scale). Patients with PHQ >0 (n=6) had reductions in depressive symptoms (-5.5; 0-27 scale); all patients with PHQ=0 at baseline also had PHQ=0 at follow-up. Patients were highly satisfied with LR-OT (satisfaction score 4.9; 1-5 scale). Provider interviews indicate that LR-OT is well-accepted and facilitates more effective patient care through providing detailed insights into patients' daily life circumstances.

Conclusions. This study has shown the feasibility and acceptability of providing LR-OT in a safety-net primary care clinic, and demonstrates promising preliminary data on its positive impact on health, quality of life, and patient satisfaction.

11

Participatory Approaches Used to Inform a Health Policy Curriculum and Address Determinants of Equity

Teteh D, Hawkins M, Scheu J, De Luca E, Nimako S, Luna C, Giron J, Spinks J, Vasquez M, Ramirez D, Penny M, Gardner A, Lambert S, Baltazar A

Introduction. The Healthy Communities' movement has transformed how health is defined and represented in interventions seeking to improve health equity. The inherent principles of the movement includes partnerships across diverse sectors, including government, to address the issues impacting marginalized communities. Interventions seeking to build healthier communities have traditionally used project based methods, which often solely addresses the "symptoms" of the issues involved. Pioneers of the field have argued for a more systems level or policy approaches to sustaining healthy community initiatives.

Description of evidence and theory used to inform development/implementation. The Randall Lewis Health Policy Fellowship program is an example of a policy driven Healthy Communities' initiative in Southern California. The purpose of the program is to ensure the development of professionals who possess the necessary skills to influence change in their local municipalities. The program's curriculum is rooted in the understanding of the health inequities in our communities are a social injustice requiring innovative solutions from diverse disciplines. The curriculum developers used a community-based participatory approach that included contributions from business, non-profit, local government, hospital, academic, and department of public health systems.

Description of program activities and outcomes, or plan to evaluate outcomes. The curriculum is comprised of nine modules and includes: GIS certification; personal & professional skills development; urban planning; communication skills-building; health equity and community capacity building objectives. Launched in 2017, Fellows that have matriculated through the program expressed enthusiasm for the exposure to new concepts and highly useful tools. Fellows are encouraged to employ these new tools and skills in a community setting under the guidance of a site preceptor.

Conclusions/Recommendations for Practice. As the curriculum is newly implemented, additional cycles are needed to gather outcomes and impact evaluation data. Fellows contribute to ongoing modifications and adaptations of the curriculum via surveys and key informant interviews. The curriculum was specifically developed for graduate students to enhance the practical learning component of their professional education. This model appears to be valuable in engaging various community partners in the development of a new generation of more competent and resilient professionals.

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Organizational Supports for Evidence Use among Private Human Service Agencies: A Cluster Analysis

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Background and Aims. Little is known about strategies that private human service agencies use to facilitate evidence use by staff. This study identifies organizational supports used by private agencies in six states and examines factors associated with agency use of these supports. Specific supports examined include technical infrastructure (data systems and/or tools), knowledge management (KM) infrastructure (i.e., other dedicated resources such as agency staff), strategic alignment (efforts to establish culture prioritizing evidence use), and linkage and exchange efforts (ties to external partners).

Methods. Data are drawn from a web-based survey administered to senior executives in six states, including CA (n=219 of 414; response rate 53%). Hierarchical cluster analysis was used to categorize agencies into 5 mutually exclusive clusters based on similarity in organizational supports. Clusters were validated using predictive discriminant analysis. Multinomial logit models examined contextual and organizational factors associated with cluster membership. Specific factors examined included competition, funding sources, accreditation, institutional pressures for evidence use, size, membership in a larger network, service diversity, and leader activities.

Results. Cluster 1 included agencies with above-average technical infrastructure but below average use of other supports. These agencies had highly diverse service arrays but limited leader boundary-spanning activity. Cluster 2 included agencies with above-average technical infrastructure and strategic alignment but limited KM infrastructure and linkage and exchange efforts. These agencies were large, with highly diversified service arrays, and reported above-average leader boundary-spanning activity and competition with public child welfare agencies. Cluster 3 included smaller agencies with below average investment in organizational supports and low institutional pressures for evidence use. Cluster 4 included larger agencies with above-average technical infrastructure and linkage and exchange efforts, high institutional pressure, but below average KM infrastructure. Cluster 5 was comprised of agencies reporting above average use of all organizational supports for evidence use. These agencies were smaller, offered less diverse services, and reported high percentage of child welfare revenue.

Implications. Agencies varied significantly in use of organizational supports for evidence use. Findings provide insight into varying capacity for evidence use among private child and family serving agencies, and into factors that motivate differential investment in such supports.

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Implementation of an Emergency Department to Buprenorphine-Based Medication Assisted Therapy Protocol at LAC+USC Medical Center

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Background and Aims. Opioid use disorder (OUD) is an increasing public health issue, and medication assisted therapy (MAT) has been shown to be an effective harm reduction strategy, improving mortality and morbidity. According to the Centers for Disease Control (CDC), opioid related emergency visits increased by 29.7% between July 2016 and September 2017, and opioid overdose deaths increased 27.7% between 2015 and 2016. ED initiation of buprenorphine and MAT has been shown to significantly increase engagement in treatment and reduction of illicit opioid abuse. The aim of this project was to design and implement a protocol for initiation of buprenorphine-based MAT in patients presenting with OUD, partnering with the primary care network to provide long-term outpatient therapy.

Methods. A buprenorphine induction protocol was designed with assistance from faculty from the LAC+USC Division of Toxicology within the Department of Emergency Medicine (DEM) and matched with creation of a conduit to LAC+USC Ambulator Care Clinics. This outpatient referral bridge will expand to include multiple other outpatient provider networks to create a comprehensive referral network for most common insurance types and geographic locales of patients using the LAC+USC DEM.

Results(Design). Outcomes to be measured using Electronic Health Record data will include DEM baseline data (opioid associated diagnoses, naloxone kit prescriptions, buprenorphine prescriptions, outpatient referrals for MAT). Follow up measures will include (successful initial visit to outpatient MAT providers, continued adherence to MAT at 6 months). Data will be collected longitudinally to evaluate planned interventions such as warm handoff systems, buprenorphine prescribing protocols, expanded primary care networks, and staff member opioid education.

Conclusions. Opioid use disorder treatment is a dire need both nationally and locally. The DEM is a frequent touch point for opioid use patients due to their medical vulnerability. MAT has substantial potential to interrupt the cycle of addiction in these patients. This design and implementation project will create a protocol for ED initiation of long term buprenorphine-based MAT. By using an implementation science framework, we can measure the degree to which the ED can be leveraged to expose more patients to interventions like naloxone prescription kits, buprenorphine, and linkage to outpatient MAT.

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Advancing Patient-Centered Outcomes Research Through a Community-Academic Partnered Research Conference on Teen Emotional Well-Being

Fein E, Martinez A, Alo A, Bross R, Chung P, Murillo J, Stewart C, Valeri A, & Chung B

Background and Aims. Forging partnerships between under-resourced communities and academic researchers to address a community-identified problem is one possible way to reduce health disparities and increase community research engagement. In 2018, a team of community advocates and academic investigators at LA Biomed/Harbor-UCLA sought to address a community-voiced need to learn about improving teen emotional well-being (EWB) by asking participants at a research conference about their understanding of the topic.

Methods. At the conference, held at a local cultural arts center, community discussion groups of teens in one room and adults in another room responded to four open-ended questions. Here we include analysis of teen responses to two of those questions: "How would you describe a teen that is: [1] emotionally healthy and successful..." and "[2]...emotionally unhealthy and unsuccessful in your school or community?" The Assistant Principal of a local public charter high school selected 42 students to attend the conference based on their interest in teen EWB. This group was 83% Latino, and 14% Black, from a school system in which 92% of students qualify for free or reduced-price school meals. The first author has used inductive content analysis to preliminarily identify themes and compare them with NIH Toolbox EWB categories. He will partner with the teens to complete the analysis.

Results (preliminary). Teens identified the following categories of teen EWB: negative affect, psychological well-being, stress/self-efficacy, and social relationships, all of which rely on subjective report. Teens also identified observable behaviors as additional categories, such as: being active in different areas of life, not engaging in bad behavior, reaching out to others for support, and supporting others. In contrast, the NIH approach to defining EWB was an expert-driven process, and resulted in the exclusion of observable behaviors as categories.

Conclusions. This project illustrates the value of engaging teens in research to understand their own health. Valid, robust measures of teen EWB should address not only NIH expert-identified subjective categories or the absence of mental illness, but also teen-identified observable behaviors.

15 Experiential Peer Support Group for at Risk Youth

Jimenez E, Mena S, & Serrano V

Introduction. California Mental Health Connection is an outpatient mental health service dedicated to assisting victims of crimes afflicted with complex trauma/co-occurring disorders. For 24 weeks CMHC held a Youth Support Group, for adolescents between the ages of 13 and 17. The youth have been victims of crime, or are at risk youth due to their race, gender, and sexual orientation. Our interest primarily lies on the effectiveness of the youth group on consolidating a sense of self such as self-identity, through education, resources, and support.

Method. Our team looked for adolescents ages 13 to 17 experiencing various forms of trauma and risk factors such as family history of violence, substance abuse, suicide attempts, cyberbullying and those in the underserved communities. Prospective members were referred to the group through community outreach, referrals through probation officers, and from parents actively receiving mental health services at the facility.

Through mixed methods, our team measured the effects of the youth group through observation and standardized trauma checklist. Prior to commencing the youth group, members' extent of trauma was measured using the Trauma Symptoms Checklist-40. At the 24-week mark of weekly 2 hour sessions, group members were asked to evaluate the group's effectiveness in the following: providing a safe space, appropriate peer support, mentorship, and introduction of relevant discussion topics to their personal lives such as hospitalization or suicide attempts. In addition, members were re-evaluated using the TSC-40, and the PHQ-9 was introduced to measure symptoms.

Results. The initial TSC-40 that group members completed were graded using the TSC-40 evaluation scale and used as a reference for future assessments. According to the initial TSC-40, the trauma index which was overall highest among group members was dissociation and depression. Results from the second TSC-40 indicate that the indexes of both dissociation and depression dropped.

Discussion. Our study indicates that intervention through peer support and role modeling in a safe environment encourages adolescents to address traumatic experiences, improve everyday parental communication and problem solving at school with peers. During this critical window of opportunity for growth and change, integrating psychoeducational groups in an adolescent's life encourages a better mental health quality.

16 Strategies for Full System Scale and Spread: A Systematic Review

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Background and Aims. While innovations and improvements in care delivery are continuously available, they are often not spread across all settings that would benefit from their uptake. This systematic review seeks to describe what strategies have been used to scale up and spread clinical and administrative practices across multi-site healthcare systems, with special attention paid to sites with poor performance or that may be hard to engage in improvement initiatives. These include macro-level strategies, such as learning health system infrastructure, as well as micro-level strategies such as coaching of individuals.

Methods. We searched for literature in multiple databases using terms related to "scale and spread" and "learning health systems". We also identified publications from relevant projects in a VA-specific database. Publications are excluded if they are not relevant to healthcare delivery settings, discuss spread in low income countries, discuss spread without data from specific examples, or include a limited rollout (< 10 sites) that does not specifically include hard-to-engage or low-performing sites. The data synthesis is narrative. While preliminary findings are reported here, additional data extraction and analysis is ongoing.

Results. We identified 1,907 titles for review. Of these, 247 full text articles were eligible for inclusion. Three models for spread identified thus far at the macro level include (1) organizational infrastructure to support spread of multiple initiatives within a specific topic area, like pediatric rheumatic diseases; (2) an initiative-specific spread, which describes the uptake of a specific innovation across a large number of sites, such as the national spread of telemedicine in Norway; and (3) integrated systems with infrastructure that tackle high priorities within their institutions, like Kaiser Permanente Northern California and Geisinger.

Conclusions. This project is ongoing, including analysis of micro-level strategies. Preliminary findings suggest that there are several macro models for spread that describe different overarching strategies or objectives, and may employ similar micro strategies. Little evidence has been identified thus far that focuses on or provides discussion of strategies for reaching sites that may be harder to engage or that have particularly low performance directly on hard-to-engage sites.

17 The Information, Doctors, and Appointments are in Harmony: A Qualitative Assessment of Patient Experience with Newly Integrated Health Homes

Siantz E, Henwood B, & Gilmer T

Introduction. There is increasing enthusiasm for delivering integrated physical and behavioral health care by way of Health Homes to persons with mental illness and co-occurring chronic conditions. But, despite the Triple Aim's call to action to "embrace patient experience as a critical implementation consideration," few studies have reported on this using qualitative methods. This qualitative study aims to explore the experiences of patients who have received services from the Behavioral Health Integration and Complex Care Initiative (BHICCI), which is a large-scale system redesign that delivers integrated care through Health Homes to persons living with mental illness in Southern California.

Methods. Patients and providers from five community-based organizations involved in the BHICCI participated in the present study. As part of the larger implementation evaluation, qualitative data were collected from eight patient focus groups (six in English, two in Spanish), and from half-day site visits at these five clinics which included semi-structured interviews with staff members and clinic leadership. Staff interviews focused on their implementation process and perceptions of how patient experiences have changed under BHICCI. Focus groups and interviews were audio recorded, professionally transcribed, and coded using Dedoose. Transcripts were analyzed using constant comparative analysis informed by grounded theory.

Results. We spoke with 54 BHICCI patients in six English language focus groups and two Spanish language focus groups as part of the BHICCI's larger implementation evaluation. Three themes emerged: (1) "care coordination is crucial" - patients welcomed the support of care managers to navigate the newly designed system; (2) "awareness of implementation challenges" - patients described the experience of organizational challenges, such as hiring new medical providers to accommodate the influx of patients with complex health conditions; and (3) "integrated care has relational aspects" - patients described the importance of provider engagement with the emotional and spiritual elements of illness and recovery.

Conclusions: This study highlights the importance of understanding and incorporating patient experience into the design of integrated care systems. Targeted efforts are needed to ensure that health care quality improvement initiatives prioritize patient feedback and perspective.

18 Improving Methods for Implementing Computer-Based Mapping in Home-Based Primary Care Programs

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Background and Aims. Home-Based Primary Care (HBPC) programs provide services for patients with complex, chronic conditions. Geographic Information System (GIS) mapping programs can improve efficiency of access to care. The Los Angeles VA HBPC developed use of GIS maps to support patient care. However, HBPC teams generally have little experience with GIS mapping. We describe the development of implementation methods for spread of GIS adoption.

Methods. This project uses a multi-disciplinary implementation approach to work with selected HBPC partner sites that are learning and using GIS mapping via a secure, user-friendly internet portal. Mixed-method, site-level evaluation uses quantitative utilization and survey data, plus qualitative data from semi-structured interviews, to assess extent of adoption, satisfaction, facilitators and barriers, and to explore impacts. Formative evaluation feedback from partner site experiences is used to refine implementation tools and processes, resulting in development of a set of tools that includes training, technical support, and other materials.

Results. Implementation has spread from Los Angeles (2012) to 30 current sites. Sites represent small, medium, and large HBPC programs, in various geographic areas nationwide, both urban and rural. By fall 2017, 24 sites were using maps they had made; 4 others were in the training process; 2 were on hiatus. The most common uses included: assigning patients to providers (n=23; 96% of map users), managing territories and day-to-day travel (n=21; 88%), and emergency preparedness and management (n=18; 75%). The most common barriers to GIS use are staff turnover and competing demands. In response to feedback, training materials were revised and made more easily accessible. In-depth evaluation for one site, who used GIS maps to optimize patient reassignments while reducing staff in an expanded clinical service area, found that nurse practitioners involved in the reassignments saw 33.3% more patients (60.0, Q1FY2016, to 90.3, Q1FY2017) and traveled 30.4% fewer miles per patient (128.9, Q1FY2016, to 89.7, Q1FY2017) after GIS-supported reorganization.

Conclusions. GIS use can increase access to HBPC services by improving efficiency of travel to patients' homes. With tailored implementation support, a wide range of HBPC programs can learn and use on-line GIS mapping tools, given adequate staff skills, training, and time.

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Implementation of an Obesity Care Model in a Federally Qualified Health Center to Prevent and Control Childhood Obesity

Schmied EA, Ibarra L, Chuang E, Lin SF, Arredondo E, & Ayala GX

Background. Childhood obesity continues to be a leading public health issue in the United States, affecting nearly 20% of children ages 6-19 years old. Given the serious and long-term consequences associated with childhood obesity and its disproportionate impact on low-income racial/ethnic minority populations, it is critical to develop interventions that are not only effective but feasible to implement with these populations. The objective of this study was to evaluate the implementation of an Obesity Care Model (OCM) for the prevention and control of childhood obesity in a Federally Qualified Health Center (FQHC) serving a predominantly Mexican-origin, low-income population.

Methods. This healthcare intervention was implemented as part of a CDC-funded multi-sector, multi-level Childhood Obesity Research Demonstration study (CA-CORD). The study occurred between 2012 and 2015 in three clinics in an FQHC in Imperial County, CA. Consistent with the OCM, the intervention changed clinic policies and practices related to the assessment and treatment of childhood obesity, modified the electronic health records (EHR) system to accommodate practice changes, and increased patient and family self-management support via a community health worker-led (CHW) family wellness program. Trainings and support materials were developed for clinic staff and CHWs to encourage adherence to new policies, practices, and programs. Primary data include implementation logs, clinic manager and clinician interviews, annual reports submitted by clinics, and EHR data about pediatric encounters. Data were analyzed to determine reach, dose, and implementation fidelity at the researcher-to-provider and provider-to-patient levels.

Results. Implementation fidelity was high at the researcher-to-provider level; the FQHC Board of Directors and all clinics agreed to adopt all proposed policy and practice changes, including EHR changes. Thirty providers (83.3%) and seven CHWs (70%) completed offered trainings. Preliminary analyses of provider-to-patient implementation suggests clinic staff adhered to new practices for assessment and treatment of overweight/obese pediatric patients.

Conclusions. In this demonstration study, an OCM was implemented with a high degree of fidelity in participating clinics, in large part due to the buy-in of clinic staff and providers. These results indicate implementation within similar healthcare settings may be feasible. Efforts to further assess implementation at the provider-to-patient level are ongoing.

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Using Medical Assistants and an Evidence-Based Video Tool to Promote Advance Care Planning in A County Clinic

Kaltman J, Patel A, Tillage V, Volandes A, Davis AD, Rothman E, Akerele D, & Soni SM

Background and Aims. There is a growing need to improve advance care planning (ACP) in the county population. Use of medical assistants (MAs) and video-based education have not been performed in this setting. Our aims for the study are 1) to assess the feasibility of implementing an ACP video education tool in the clinic and 2) to measure the effect of MA ACP education and video-based education on patient motivation to fill out advance directives (ADs).

Methods. MA's received training on ACP discussions and ADs. This involved scenarios to address patient-specific barriers to AD completion. From 1/2018-5/2018, a multi-language video on ADs produced by ACP Decisions © was shown to patients over the age of 50. Pre/post-surveys were administered to MAs to assess self-reported knowledge and comfort in discussing AD's. A post-video survey assessed patient's comfort with the video and willingness to recommend the video to others. Two weeks following visits, both patients receiving the video and those receiving the MA intake only were contacted regarding their motivation to complete an AD. All data was analyzed in REDCap.

Results. MA mean knowledge (pre: 6.5, N=13; post: 8.0, N=17) and comfort (pre: 6.2, N=13; post: 7.8, N=17) scores improved after receiving ACP training (out of 10). Forty-eight patients received the video and were mostly female (67%) and Spanish-speaking (65%). Most felt very comfortable (N=38, 79%) watching the video and would definitely recommend (N=43, 90%) it to others. Of eight patients contacted after their visit, two received the video while six received only MA education. Both patients who viewed the video had reported it had made documents more clear. Of the 6 patients who received MA education, 4 had no recollection of a discussion or receiving documentation while two found education helpful. No patients had yet completed an AD.

Conclusions. MA training improved knowledge and comfort with discussing ADs. The majority of patients viewing a brief ACP video reported feeling comfortable and willing to recommend it to others.

Film as a Health Communication Tool to Understand Perceptions and Attitudes in Multiple Sclerosis- The FHAMS Project Part 1

Martinez A, Gonzalez L, & Amezcua L

Background. It is estimated that the number of Hispanics with multiple sclerosis (MS) in the US will increase, given the estimates that the proportion of Hispanics in the US population will rise from 14% in 2005 to 29% by 2050. Despite MS now being increasingly diagnosed among the Hispanic population, we found that perceptions of MS in this population may be driven by sociocultural idioms which could be influencing poorer disease outcomes particularly among immigrants. Audio-video technologies have been shown to be successful edutainment tools in promoting Hispanic health and improve outcomes in other chronic conditions.

Objectives. To improve MS awareness and cultural perceptions using short-film as an intervention.

Methods. Study Participants: Hispanics with a diagnosis of MS who are willing to view a film, complete a questionnaire, and engage in focus group sessions. Short film: “Dentro de Mi” is a video that presents MS information in the format of a short-film documentary, in which non-fictional stories unfold over several shots (viewing time: ~10 minutes) – created for Hispanic patients and their families facing MS. Filmed in English, the story was developed using a multidisciplinary approach by a team of public health and medical professionals, and was designed to resonate with Hispanic cultural values that are salient in Southern California, home to a largely Mexican American and Central American Hispanic population. The ease of dissemination and the opportunity for repeated viewing at low cost to the patient are two clear benefits of testing this intervention.

Questionnaire: The validated Brief Illness Perception Questionnaire (Brief IPQ) is being administered before and after viewing of the short film.

Focus Groups: Session consisting of 12-15 participants expected end of May. Mix method analysis using qualitative and quantitative data.

Conclusions. The use of short film may modify perceptions of MS in those of Hispanic background. Our long-term goal if successful, is to eventually disseminate the film to MS centers across the US and further develop new short-film interventions addressing other important social and behavioral topics in this MS community.

Implementation and Evaluation of an Evidence-Based Physical Activity Screening and Promotion Program in Six Primary Care Clinics

Linke SE, Rabin B, Kronick R, Sallis JF, Strong D, Tai-Seale M, & Kallenberg G

Background and Aims. Insufficient physical activity (PA) is a leading risk factor for most chronic health conditions. Identifying patients at higher risk of these conditions due to their insufficient levels of PA is one of the highest priorities given evidence that insufficient PA creates a significant financial burden on the healthcare system. Despite evidence for the cost-effectiveness of PA counseling in primary care, only one-third of patients reports receiving PA counseling from their PCPs. Exercise is Medicine (EIM) is a global health initiative that is committed to the belief that PA is integral to the prevention and treatment of diseases and should be regularly assessed as a vital sign and “treated” in the healthcare setting. This proposal aims to systematically adapt and implement the evidence-based EIM within UC San Diego Health System’s six primary care clinics AND utilize a quality improvement (QI) model to conduct rapid Plan, Do, Study, Act (PDSA) micro-cycles to adapt it accordingly throughout the study. It also aims to conduct a comprehensive evaluation of the program.

Methods. We will use PRISM (Practical, Robust Implementation and Sustainability Model) to guide a comprehensive pre-implementation evaluation and adaptation of EIM protocol, materials, and delivery strategies. We will use the Learning Evaluation QI model to iteratively pilot, refine, and implement the PAVS and EIM within each of the six primary care clinics using rapid, 3-month PDSA micro-cycles followed by learning meetings to gather feedback and generate ideas for improvement to optimize workflow. We will use the Stirman Framework to systematically assess modifications and adaptations made to the existing evidence-based screening and brief intervention throughout its implementation. We will use PRISM to guide a comprehensive quantitative and qualitative program evaluation to help determine the program’s acceptability and potential for successful long-term sustainability within the UC San Diego Health System.

Conclusions. The information obtained through the proposed study will be an invaluable resource for optimizing the implementation of the EIM initiative to meet patient, provider, and healthcare needs to increase the effectiveness and sustainability of the program in the long-term, leading to better implementation of evidence-based PA screening and promotion programs in healthcare settings.

23 Implementing an Effective Hospital-Based Violence Intervention Program at a Los Angeles County Trauma Center

Terao N, Hsieh D, Samra S, Salas A, Murray J, Deane M, & Carrillo P

Background and Aims. Violent crime disproportionately affects urban communities of color. South Los Angeles and South Bay of Los Angeles experience the highest rates of homicide among adolescents and young adults in Los Angeles County. The implementation of a hospital-based violence intervention program (HBVIP) at Harbor-UCLA aims to engage victims of violence from these areas and provide support with mental health, substance use treatment, job placement, housing, and legal services with the goal of reducing the recurrence of violent injuries.

Methods. Implementation: Initial implementation included analysis of Harbor-UCLA's trauma registry data to evaluate the need for violence intervention services, a literature review of HBVIPs, and outreach to experts in the field of HBVIP. Interdisciplinary meetings were then held between the departments of emergency medicine, surgery, and social work, to secure a collaborative foundation to the initiative. Harbor-UCLA partnered with Southern California Crossroads, a community-based organization with almost two decades of experience in hospital and community-based violence intervention efforts. Additional partnerships were formed with agencies of Public Health, Mental Health, and law enforcement, to foster wrap-around services to victims of violence. Between May 2017 and April 2018, the HBVIP operated in a pilot capacity at Harbor-UCLA three half-days a week engaging patients. During this time, the program offered violence prevention services to Harbor-UCLA patients who were victims of gunshot wounds, stabbings, and assaults. A total of 126 patients were approached and 71 patients agreed to receive services. **Improvement:** As a full-time program is implemented, there will be a monthly process evaluation to assess enrollment and delivery of and satisfaction with services so that any suboptimal aspects of the intervention can be addressed promptly. An outcome evaluation will be performed based on pre- and postintervention surveys, semi-structured interviews, and objective measures such as recurrent violent injuries, length and cost of hospital stays due to recurrent injuries, and mortality.

Conclusions. Early research regarding the efficacy of HBVIPs has shown promise in reducing re-injury rates and subsequently cutting hospital costs by millions of dollars. This initiative offers a roadmap for implementing a collaborative and interdisciplinary HBVIP in a region highly burdened with interpersonal violence.

24 Emergency Department Conduit to Connect Uninsured and Undocumented Patients to Insurance Enrollment and Legal Resources

Schneberk T, Morrison J, Menendez T, Ford K, Inkelas M, & Trotsky-Sirr R

Background. Emergency Departments (EDs) are disproportionately responsible for the care of vulnerable populations such as the undocumented. Due to barriers to accessing insurance, these patients are disproportionately dependent on the ED for care. In a county with 1 million undocumented individuals, medico-legal partnerships provide an opportunity to reduce barriers to health and support patients with unaddressed legal needs associated with their documentation status. We discuss implementation data from a medico-legal conduit between a large public safety-net ED and an adjacent community center to provide patients with insurance enrollment assistance and legal services as a combined social care bundle.

Methods. In the ED, we used the neutral already existing proxy of uninsured status to identify individuals who are likely to be undocumented (>60%) for referral to a nearby community wellness center (TWC). At TWC, individuals are screened for a variety of social determinants of health and are referred to community-based services including bundled health care enrollment and immigration legal services. Data on total ED patients referred to TWC, throughput of ED-referred patients, subsequent insurance enrollment, and immigration legal services referrals were collected and trends examined over time.

Results. Over the 6 months of the pilot, just over 9000 people were referred upon discharge from the ED to TWC, of whom 1236 (14%) presented to TWC. 622 (50%) of these patients were referred to insurance enrollment, of which 49% were enrolled in MediCal and 51% were enrolled in our county-run comprehensive healthcare program for undocumented individuals. Of those who used insurance enrollment services, 96 (15%) elected to utilize immigration legal services.

Conclusions. This pilot of a medico-legal conduit demonstrates proof of concept for a novel pathway for utilizing the ED to address immigration legal needs and undocumented status as modifiable determinants of health. It also illustrates the rates of referral and patient engagement in using a pathway that connects already-existing resources without requiring screening for sensitive information regarding documentation status in the ED. This pilot will be the foundation for further interventions such as warm handoffs by patient navigators, larger immigration legal aid capacity, and expansion to satellite EDs.

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Linking Primary Care Patients at LAC+USC Medical Center to Community Resources for Chronic Disease Management through a “Wellness Navigator” Program at The Wellness Center at the Historic General Hospital

Morrison J, Menendez T, & Kuo T

Background. As health systems evolve to provide quality integrated care, one ongoing challenge is how to link patients to community-based resources for chronic disease prevention and management. At Los Angeles County’s largest safety-net medical center, health providers have direct access to community-based organizations that provide these resources through a centralized “Wellness Center” staffed by Wellness Navigators. **Methods:** “The Wellness Center” (TWC) co-locates more than 20 community-based organizations on the medical center campus to provide coordinated services. Wellness Navigators work with clients to access a wide range of individual services and group programming including Evidence-Based Programs (EBPs) such as the National Diabetes Prevention Program and the Stanford-model Chronic Disease Self-Management Program, in addition to exercise classes, cooking classes, mental health counseling, health care enrollment advocacy, legal services, and integrative health services for pain-management. **Results:** Since opening three years ago, TWC has served more than 15,000 unique clients with an estimated 75,000 visits per year. Twenty percent of clients reported a diagnosis of diabetes, 58% percent were uninsured, and 53% percent reported one or more ER visit in the previous 6 months. In 2016, 2,573 clients received health care enrollment services, 651 legal advocacy, 996 received weekly therapy for either mental health or domestic violence, and 108 participated in EBPs for chronic disease management. **Conclusion:** TWC provides a promising model to connect high risk populations to community-based organizations that provide resources for chronic disease prevention and management. Innovative approaches for coordinating self-care resources has become ever more important, especially for improving quality of care, reducing costs, and removing barriers to better chronic disease control. TWC will be tracking health outcomes and indicators of progress (e.g., level of service utilization, potential cost savings due to more effective self-care) to iteratively inform its planning and programming.

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Using Improvement Science to Develop a Population Approach to Children’s Oral Health

Inkelas M, Gatewood H, McBride RF, & Crall J

Background. Dental caries is a transmissible, progressive chronic disease that affects about half of all children before kindergarten and is a leading cause of school absence. Emerging science supports risk-based approaches to dental care, which entails earlier contact with a dental provider, standard caries risk assessment in well child care, risk segmentation, risk-based periodicity of fluoride application, and healthy home routines. Challenges to this new model of care include limited availability of pediatric dental providers, siloed medical and dental services. **Methods.** This improvement science study describes results of three phases of learning collaboratives involving federally qualified health centers (FQHCs) in Los Angeles County. Between 2014 and 2017, clinics tested a risk-based and population-based approach across medical and dental care providers. The initiative used the Institute for Healthcare Improvement (IHI) Breakthrough Series model that provides an organized “all test, all learn” structure among participants, content experts, and quality improvement experts. Each collaborative included three in-person sessions with iterative testing taking place in between these sessions. Clinics are coached on measurement for improvement, change concepts, and small-scale testing, moving from testing to implementation, creating a culture of change, planning for sustainability, and high reliability concepts. Clinic teams reported monthly measures and used the Model for Understanding Success in Quality (MUSIQ) survey to consider QI capabilities that would speed their progress toward goals. Statistical process control (SPC) charts show if care improved. **Results.** Clinics achieved performance targets on caries risk assessment at the dental visit, and reviewing self-management goals at dental visits. Clinics had some success introducing risk-based scheduling and monitoring of high-risk patients. Results are dominated by special cause due to significant variation across clinics. Contextual factors show limited workforce proficiency in QI. **Conclusion.** Medical and dental providers worked effectively together to re-design workflow that detailed their respective roles, steps, and timing. Changes to be refined so that they are feasible and scalable in busy practices include true integration of medical and dental services into a comprehensive oral health strategy, with sustainable roles of personnel, hardwired re-designed workflows in clinic systems, and effective panel management.

Abstracts- Complete Works

27 Improving the Quality of Clinical Trials at Academic Research: Developing Training Modules Through an Implementation Science Process

Spinrad A, Pacifici E, Pire-Smerkanich N, & Xie A

Background. Because clinical trial results are instrumental in the approval of a new molecule or changes to the practice of medicine, ensuring accuracy and validity of data collected is critical in clinical trial conduct. This function, routinely carried out by clinical trial monitors in industry-sponsored trials, is often lacking in investigator-initiated trials conducted in academia. To address this shortcoming, we are in the process of launching a training initiative to cross-train academic research coordinators in regulatory aspects of monitoring and auditing clinical trials so that they could monitor/audit studies at their institutions. Integrating an implementation science framework into the development and launch of the initiative ensures that workforce gaps are explored and needs are addressed to improve the quality of clinical trials conducted in academia. **Methods.** This research project applied the exploration and installation stages of the implementation process by 1) exploring the need of a new initiative, 2) identifying effective training mechanisms, 3) identifying and engaging key stakeholders, 4) developing training modules, 5) creating SOPs for installation and initial implantation stages, 6) developing pre- and post- surveys to assess satisfaction of the trainees and the effectiveness of the training modules.

Results. From an exploratory survey of 60 academic researchers, we found that only 68% of respondents reported that their investigator-initiated trials were monitored. Although numerous GCP training resources exist through literature and on the Internet, most are too broad in scope and lack the practical approaches to meet the complex requirements of monitoring. An integrated approach to GCP training could help better sustain researchers that desire to learn more about specific topics, like monitoring (Arango et al, 2016). Furthermore, many require fees or institutional affiliations, making them inaccessible for academic researchers working on investigator-initiated clinical trials. Results of focus group surveying showed that our module was effective, however, focus group members wanted more information on the basics of the clinical research process incorporated in the training.

Conclusions. Finding from this study will inform dissemination and implementation research on effective training for clinical research professionals and better ensure human subjects protections and reliability of results in investigator-initiated clinical trials.

28 Organizational Readiness for Wellness Promotion – A Survey of 100 African American Church Leaders in South Los Angeles

Maxwell AE, Santifer R, Wright AL, Gatson J, Vargas RB, Chang CL, & Jones L

Background and Aims. South Los Angeles has a large proportion of African American residents, 38%, the highest rate of obesity in the Los Angeles area and among the highest mortality. These disparities exist in a setting of disproportionate rates of poverty and limited access to care. Faith-based centers are an important asset and a trusted resource in the African American community. We surveyed 100 church leaders in South LA to gain a better understanding of the readiness of churches to actively engage in health promotion.

Methods. With input from church leaders, we developed a theory-based capacity assessment survey. Capacity refers to factors that increase the success of implementing a health promotion program, including the community's awareness of the health problem, it's readiness and resources to address it. At the organizational level, capacity speaks to the agency's leadership, commitment, size and structure. We also assessed barriers to implementing wellness activities and the type of support churches would require. We started surveys with churches to which our research team had existing relationships and used snowball sampling thereafter.

Results. Interviews were conducted with senior pastors at Baptist (52%), non-denominational (16%) or Methodist churches (13%). About half (54%) had ever partnered with an academic institution to promote wellness at their church. Based on a modified Implementation Leadership Scale, church leaders were moderately involved in supporting wellness activities. Most church leaders (88%) did promote physical activity or good nutrition from the pulpit, but only 35% had established health or wellness policies or had guidelines for healthy church meals. Although 58% of churches had a person appointed for health-related activities and 41% had a health/wellness ministry, only 31% had a budget for health related activities and of those, 90% stated that it was insufficient.

Conclusions. Many churches in South Los Angeles are actively engaged in health promotion activities, despite a general lack of resources. We will discuss church leaders' needs regarding resources, their preferences regarding health promotion activities and correlates of churches' readiness for wellness promotion. Findings will guide our future collaborative health research in South Los Angeles.

29 Selection of a Child Clinical Outcome Measure for Statewide Use Using a Modified Delphi Panel Approach

Zima BT, Marti FA, Lee CE, & Pourat N

Background and Aims. The California Performance Outcomes Statute required the Department of Health Care Services to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment mental health services that will improve outcomes at the individual and system levels and will inform fiscal decision making related the purchase of services. In response, the UCLA Center for Health Policy Research was contracted to recommend a standardized measure to track clinical outcomes over time among children receiving Medicaid-funded mental health services in California.

Methods. To develop the pool of candidate measures the following tasks were completed: 1) an environmental scan of tools used by other states and nations; 2) a survey of county mental health plans and their contracted providers; and 3) an in-depth literature review of the most frequently used tools. Criteria for the candidate measures were at least 2 citations or reported use by at least 2 counties. Using a modified Delphi panel approach, a 14-member multi-stakeholder panel conducted two rounds of ratings (blind, face-to-face meeting) of the final 11 candidate measures. The rating domains were marker of effectiveness of care (face validity), scientific acceptability, usability, feasibility, and overall utility for use as a clinical outcome measure. The minimum criteria for final selection were: 1) broad age range; 2) broad range of symptoms; 3) available in California's top three threshold languages; 4) measures current functioning and can be used to measure change over time; 5) low respondent burden; 6) easy to use; 7) patient centered; 8) rated in highest range for overall utility; and 9) high quality scientific evidence.

Results. Of the 11 candidate measures, only the Achenbach System of Empirically Based Assessment (ASEBA), Pediatric Symptom Checklist (PSC), and Strengths and Difficulties Questionnaire (SDQ) had overall mean utility ratings in the high equivocal or high range (6.3 [SD=1.5] to 7.3 [SD=0.8]), but only the PSC met all nine minimum criteria.

Conclusion. Using a systematic approach, the PSC (parent version) is recommended for monitoring the effectiveness of publicly-funded child mental health care in California. Future partnered research is needed to refine methods for statewide implementation.

30 Formative Research Plan to Inform an Implementation Study Promoting Breast Cancer Screening in Faith-Based Settings

De la Torre CL, Haughton J, Wells K, & Arredondo EM

Background. Latinos are at higher risk of cancer mortality than Non-Hispanic Whites due, in part, to disparities in cancer screening. A promotora-led intervention can be an effective approach in promoting breast cancer screening. **Aims:** To describe the formative research plan to disseminate an effective promotora-led group-based education intervention to increase cancer screening among churchgoing Latinas. There is insufficient evidence in the literature review regarding the effectiveness of group-based education in increasing cancer screening. **Methods.**

Faith in Action was a faith-based promotora-led randomized controlled trial to promote cancer screening and physical activity among churchgoing Latinas age 18 to 65. The intervention had a significant positive impact on self-reported mammography and clinical breast exams in the last year and reduced perceived barriers to cancer screening. Using the Consolidated Framework for Implementation Research (CFIR), a formative research plan was developed to inform the implementation of the cancer early detection intervention arm. The formative research will inform how to increase the capacity of church leaders and promotoras to implement program activities. **Results.** The formative research consists of administering a survey to past study participants of the Faith in Action cancer early detection intervention arm, conducting focus groups with promotoras that led the cancer early detection workshops with the Faith in Action project, and interviewing leaders from the churches randomized into the cancer early detection arm. The surveys administered to study participants will collect data about their experiences in participating in the Faith in Action program and to what extent they have continued to adhere to recommended cancer screening guidelines.

The purpose of the focus groups is to gather information about the promotoras' experience implementing the Faith in Action program in their churches. The interviews with church leaders aim to gather knowledge about the organizational characteristics of their church and the challenges to implementation. **Conclusion.** Findings from the formative phase will inform the implementation study leading to the development of a dissemination study promoting cancer screening in Latino communities. Furthermore, findings will augment the limited evidence published on the effectiveness of group-based education to increase cancer screening rates.

31 Measuring Patient-Reported Contextual Distress including Discrimination Stress in the Oncology Arena

Ashing K, Etim N, Xie B, Jones V, & Napoles A

Aims. To assess patient reported distress, including discrimination distress in the oncology setting in African American and Latina breast cancer survivors (BCS).

Methods. A total of 320 African American and Latina BCS completed an 18-item stress Life Stress Scale to rate multiple sources of stress, including discrimination stress. Exploratory factor analysis was conducted using maximum likelihood methods.

Results. BCS were between 26 and 89 years (mean=54.5). Factor analysis and item refinement yielded a two-factor solution with 13 items that accounted for 47% of the total variance. Racism and discrimination items loaded on Factor 1 and accounted for 21% of the total variance. Cronbach's alpha for this 4-item scale, called Discrimination Stress, was 0.87 (95% CI = .84 - .89). Items assessing stress related to disease outcomes and socioeconomic variables loaded on Factor 2 and accounted for 26% of the total variance. Cronbach's alpha for this 4-item scale called SES and Disease Stress, was 0.85 (95% CI = .82 - .87). Responses on the Discrimination Stress factor differed significantly between African Americans and Latinos, while they were similar for items on SES and Disease Stress.

Conclusions. Findings support the important roles of racism- and discrimination-related stress and its potential impact on survivorship outcomes of racially and ethnically diverse BCS. This type of stress represents a modifiable risk factor that can be targeted to reduce cancer survivorship disparities.

32 Pathways to Quality Improvement: How Improvement Projects are Initiated in an Integrated Healthcare Delivery System

Brunner J, Chuang E, Yano EM, & Hamilton AB

Background. In many clinical settings, a chief barrier to quality improvement (QI) has been a scarcity of data and a lack of leadership around priorities for improvement. By contrast, the present-day Veterans Administration (VA) is a data-rich environment with multiple organizational structures that set priorities for improvement. In this context, a key question is how local clinicians and administrators reconcile national, regional, and local priorities to select and initiate improvement projects. Increased understanding of these pathways can enable implementation strategies that better reflect improvement projects' varied origins.

Methods. We partnered with VA's Office of Women's Health Services based on their interest in facilitating locally-driven QI that is evidence-based and informed by regional priorities. From March-August 2017, we conducted semi-structured interviews with key stakeholders at 12 VA medical centers spanning four regional networks (n=114). Participants included local and regional leaders with diverse perspectives on QI and women's health, including leaders of VA hospitals, regional networks, women's health, primary care, QI, and other operational functions. We asked participants to describe how QI projects get initiated at their facilities. We used inductive coding to develop and refine a list of pathways to QI in VA women's health clinics.

Results. We identified the following non-mutually-exclusive pathways to QI: 1) directed by regional or national leadership; 2) directed locally in response to regional/national goals; 3) grassroots conception/initiation; 4) proposal to a forum for prioritizing/resourcing potential projects; 5) "engaged work teams" or individuals throughout a facility trained in QI and encouraged to find and tackle problems; 6) part of training in QI; 7) part of medical/nursing education; 8) as a byproduct of formal research projects; 9) in response to a safety incident or "near miss."

Conclusions. Mental models of QI, shaped by personal experience, are likely to underappreciate the diversity of pathways toward QI. To best support improvement, it is important to recognize the varied means by which improvement projects are initiated. Studies that use QI as an implementation strategy would be strengthened by articulation of the ways in which outcomes relate to original QI pathways.

33 Women Veterans' Needs and Preferences for Cardiovascular Risk Reduction: Stakeholder Perspectives from the VA EMPOWER CV Toolkit Implementation Project

Dyer KE, Moreau JL, Farmer MM, Hamilton AB, Finley EP, Batuman FK, Gammage CE, Huynh AK, Moin T, Watson AB, & Bean-Mayberry B

Background & Aims: Gender disparities persist both nationally and within the VA healthcare system for many cardiovascular (CV) risk factors, such as lipid control, blood pressure control and intermediate diabetes outcomes, underscoring the importance of innovative approaches to target and promote CV risk identification and reduction in women. This analysis sought to examine stakeholder perspectives on WV needs and preferences for CV risk reduction to inform tailoring of a multi-level CV risk reduction toolkit in the context of a multisite implementation study. **Methods:** We conducted semi-structured pre-implementation telephone interviews with key stakeholders employed at two VA comprehensive women's health centers, including primary care providers, nurses, health coaches, clinic leaders and staff. Stakeholders were queried about WVs' top health needs, motivation for lifestyle change, and preferences surrounding facilitated group meetings for CV risk reduction. Interviews were audio-recorded, transcribed verbatim, summarized using a template outlining key domains, and analyzed via matrices to identify commonly-expressed themes.

Results: Stakeholders (n=15) generally regarded modifiable CV risk factors (e.g., obesity, hyperlipidemia, hypertension) to be among the most important WV health needs, especially for older Veterans. Other top needs included mental health, musculoskeletal conditions, and chronic pain. Stakeholders noted that some patients view CV risk as low priority, but tend to be most motivated to combat diabetes or pre-diabetes and lose weight. However, pre/diabetes and being overweight were also identified as the most difficult issues for patients to address. Participants believed that many WVs would strongly prefer attending women-only CV risk reduction groups, citing increased comfort discussing weight and body issues. Patients who are younger, less motivated, and/or most high-risk were regarded as the subgroups least interested or likely to attend CV risk reduction groups, due in part to busy work schedules, travel distance, and caregiving responsibilities.

Conclusions: Participants endorsed CV risk as a pressing health need facing among WVs, and stressed the value of women-only groups.

Findings are being used to tailor both the multifaceted CV risk reduction intervention and the implementation strategies designed to promote uptake of the intervention in women's health clinical settings.

34 Adapting a Family Resilience Intervention for Homeless Families with Parental Substance Use Disorders in Los Angeles County

Ports K, Horton J, Gelberg L, Ryan G, Kataoka S, & Ijadi-Maghssoodi R

Background and Aims. Homeless families in the United States have high rates of trauma and substance use disorders (SUDs). Youth in these families are at risk for substance use, mental health problems, and later homelessness. Yet, there is a dearth of family interventions for homeless families with parental SUDs, and little known on how to best care for them. We are conducting a multi-phase study using an implementation framework and community-partnered participatory research (CPPR) approach, to adapt and implement a family resilience program for families with a history of homelessness and parental SUDs. In the first phase of assessment, we conducted qualitative interviews with homeless family members and providers to understand family stressors and needs to inform adaptation, and elicited recommendations for intervention delivery. **Methods.** We conducted 56 in-depth, semi-structured interviews with 16 parents with histories of homelessness and SUDs, 15 youth in the families between the ages of 10-18, and 25 homeless service providers. Participants were recruited from transitional housing facilities in the Los Angeles metropolitan area. Interviews were audio-recorded, transcribed, and analyzed using in-depth content analysis.

Results. Families and providers expressed structural stressors, including needing better access to permanent housing and greater case management support. Housing barriers included lack of subsidized housing, unaffordable rent for market rate units, and decreased time in transitional housing. Participants expressed a need for family services to improve family communication, and cope with past trauma, substance use, and family separation. Voiced facilitators for implementing a family intervention included incorporating the intervention within housing programming on site. Potential barriers included concern about complex trauma experienced by families, and fear of losing housing related to addressing substance use.

Conclusions. Homeless families in LAC with parental SUDs and trauma have significant unmet needs. Our interviews reveal a need for increased access to housing, better understanding of these families, enhanced case management services, and a trauma-informed approach. In the next study phase, we will conduct workgroups with homeless parents and service providers for feedback on the program adaptation. Feedback will be utilized, along with qualitative findings, to adapt and pilot a family intervention for homeless families with parental SUDs within transitional housing facilities in LAC

35 Implementing Nurses as a Quality Improvement Intervention: A Clinical Nurse Leader (CNL) Case Study Examining the Dynamic Interactions between CNL and Existing Clinician Practices that Influenced Implementation Success

Bender M, & Burtson P

Background and aims. Nurses are the largest sector of the healthcare workforce and a critical component of healthcare delivery. However, little is known about how best to leverage nursing roles in care models to consistently meet quality/safety mandates. Clinical Nurse Leader (CNL) integrated care delivery is one model being adopted across the nation, with variable implementation and effectiveness reported in the literature. The purpose of this study was to identify and better understand factors that influence CNL implementation and effectiveness.

Methods. Prospective case study design was used to examine implementation of CNLs into the frontline nursing model of care in five 'pods' of a newly opened 364-bed academic medical center in Southern California. CNLs were expected to use their masters-level competencies to improve clinical practice quality. Data included observation (n=16 hours), focus groups (n=1), and interviews (n=21), which were analyzed using inductive and deductive qualitative content analyses.

Results. There were robust system-level implementation efforts, including collaborative development of an evidence-based CNL competency-based workflow by managers, clinicians, and CNLs. When implemented however, nobody knew exactly what the CNLs were supposed to be doing; the workflow was too novel for anyone, including the CNLs themselves, to understand how to incorporate it into their clinical routines. Clinicians, even CNLs to some extent, reverted to previous knowledge about familiar nursing roles, such as the resource nurse, and expected/manifested that type of delineated practice. This created a tension between CNLs improving quality or responding to in-the-moment clinical needs. Over time, CNLs transformed their workflow to better align with contextual clinical realities, which resulted in less tensions and ultimately more practice quality improvements, for example physicians adopting new rounding structures with more interdisciplinary information sharing, and staff nurses making a practice of 'handing off' patient information to CNLs every morning.

Conclusions. Robust implementation strategies were necessary but not sufficient for success; adoption was heavily influenced by how CNL practice could be related to existing clinical knowledge and practices, the process of which consequentially changed both CNL and clinician practices. Success depended on the nature of these changes and their subsequent functionalities.

36 Heterogeneity of Features of Patient-Centered Medical Home Models in Published Literature.

Jolles MP, & Mittman B

Background and aims. Patient-centered Medical Home (PCMH) care transforms primary care to deliver comprehensive, patient-centered, coordinated, accessible, and high quality care. Despite policy and practice support and significant investment in implementing this intervention across multiple care settings, results of PCMH implementation have failed to meet expectations. A recent meta-analysis found mixed evidence of benefit impacts on service access, quality and costs. High heterogeneity levels in PCMH features and contextual factors are likely contributors to mixed findings. Research efforts viewing PCMH as a complex health intervention can generate insights into the mechanisms by which PCMH achieves its effects. It can also explicitly address heterogeneity by distinguishing PCMH care functions (the intervention's basic purposes) from forms (service arrangements/activities meeting each function). An ongoing partnership with four FQHCs in Southern California is addressing this area of research. One aim for this project is to develop a scoping literature review to identify PCMH related system needs, core functions and forms.

Methods. We identified primary care delivery needs, associated care functions, and common forms found in published PCMH models from 2007 to 2017. We identified relevant articles through electronic databases (PubMed, Embase, Google Scholar and Web of Science), reference lists, websites of federal, national and professional organizations, conference proceedings and white papers/reports. We used the search results to chart the data, summarize and report the results as a detailed PCMH Function & Form Matrix.

Results. We found high variation in published PCMH care model features and their core functions and forms. Most studies used these terms interchangeably and failed to distinguish between functions and forms. PCMH features were often not aligned to system needs and contextual factors.

Conclusions. A consolidated PCMH Function & Form Matrix offers guidance for future research and implementation efforts of PCMH arrangements and guidance to tailor PCMH forms to local needs. Successful transformation of primary care settings into patient-centered coordinated care delivery systems must build on the foundation of a clear understanding of PCMH goals, common core functions and forms adapted to local settings. Lack of clear national guidance on how PCMH arrangements should be designed to meet local needs contributes to disappointing evaluation results.

37 What Motivates Medical Students to Exercise? A Randomized Controlled Trial of a Self-Efficacy-Based intervention

Ohman RE, Leuchter RL, Seger CD, Stuber ML, & Croymans DM

Background and Aims. Prevalent across training institutions nationwide, medical student stress and burnout have been shown to harm multiple aspects of students' health. Well-being research has demonstrated a link between stress and physical activity, proposing that exercise may have a protective effect on burnout. Despite increasing wellness research, there remains a paucity of randomized trial data supporting specific interventions targeting medical student well-being. We hypothesized that targeting self-efficacy would increase physical activity among pre-clinical medical students. Our primary aim was to examine the effects of a weekly, structured, self-efficacy-based intervention on physical activity and stress.

Method. We conducted a 13-week restricted-randomized single-blind trial of pre-clinical second year medical students at the David Geffen School of Medicine at UCLA. The intervention was designed to increase students' exercise self-efficacy by the principles of the Theory of Planned Behavior. Outcomes included physical activity and sleep as monitored by Fitbit Charge HR devices as well as measures of stress, self-efficacy, exercise feelings/attitudes, and social persuasion assessed weekly by validated instruments.

Results. Of 70 eligible students, 60 students (86%) were selected and randomized into either a control (n=30) or intervention (n=30) group. The intervention group experienced a significant decrease in exercise self-efficacy ($p<0.01$) and the intervention caused no significant change in physical activity levels. Though students were found to be poor predictors of their own physical activity, validated physical activity instruments were found to have significant predictive power for actual levels of future exercise ($p<0.01$). Additionally, positive associations of each of the following were detected: greater social modeling and mastery experience with increased exercise ($p<0.02$), negative exercise attitudes with higher globalized stress ($p<0.01$), and positive exercise attitudes with higher self-efficacy ($p<0.02$).

Conclusions. Rigorous and constrained goal setting in the driven and motivated population of medical students may have a de-motivational effect by decreasing self-efficacy. Randomized sub-groups within the intervention arm, instead of sub-groups based on student preference, also may have limited the impact of social persuasion. As evidenced by positive associations that were significant over the course of the study, targeting self-efficacy and exercise attitudes is still an effective tool to effect change in medical students' physical activity and perceived stress.

38 Promoting HPV Vaccination Using Socially Engaging E-Narratives

Hopfer S, Hecht M, Miller-Day M, Ray A, Belue R, & McKee F

HPV is a significant public health problem whose prevention and treatment, like other sexually transmitted infections, is confounded by issues of morality, views of science, and the challenges associated with medical compliance. Although effective prevention is available in the form of a vaccine, vaccine uptake is not anywhere near universal and lags significantly behind other adolescent vaccines. Like many medical advances, implementing strategies for taking these practices to scale is a challenge, something that is further complicated by vaccine resistance within the U.S. This presentation reports on successes and challenges to date, of overcoming obstacles to wide scale dissemination through a narrative, e-health intervention call Women's Stories. Women Stories began as a narrative intervention for college-age women delivered via videos displayed on laptops with the goal of having the intervention delivered in student health centers to efficiently reach large audiences. Narratives are an ideal communication strategy for reaching resistant and/or uninformed or low involved populations, as is the case with the HPV vaccine. The intervention significantly increased vaccination during a randomized clinical trial, almost doubling the uptake, resulting in recognition by the U.S. National Cancer Institute (NCI) as a "research tested intervention program". Even with these outcomes and this recognition, research tested interventions such as Women's Stories are seldom ready for wide spread use because of individual and institutional barriers. Our project overcame individual barriers using technology to deliver a narrative intervention, Women's Stories, to people seeking medical care in a clinic setting where they are more receptive to health information. Additionally, delivering curriculum content in video/film format retains fidelity of delivering content regardless of context. Institutional barriers and the challenge of scaling up were overcome through partnering with a community-based health care system, Planned Parenthood, that is one of the leading providers of women's health care. In contrast to the "build it and they will come model" commonly used in public health, we argue for starting with the end user and integrating the intervention into their existing system. Technology played a role in accomplishing both goals. Challenges remain in delivering e-narrative interventions that integrate into the workflow of primary health care groups. The presentation describes this innovative intervention and the challenges of integrating e-narratives for HPV vaccine promotion into the clinic setting.



Thank You!

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